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FOREWORD

WETHERBEE FORT, M.D.

PROGRESS, PEACE, AND PLENTY. These three words, as defined in Webster's dictionary: Progress, a proceeding forward; Peace, a state of friendly relations; and Plenty, an abundance, may most aptly be applied to the Doctors Hospital of today.

The pages of this Journal are replete with historical sketches, articles of recent improvements, and the future aims and purposes of the Doctors Hospital. This Foreword is in no way an attempt to elaborate on any of these because, even if I were so inclined, it would not be possible for me to do so in a short foreword. There are, however, a few very important phases of this magnificent transformation from, shall we say, a fair to a good hospital, that do evoke some just comments.

It was during my terms as Vice-President and President of The Baltimore City Medical Society, in the years 1952 and 1953, that a formal request for a survey of the Doctors Hospital was received by the Society. The Society was asked to appoint a professional committee, comprised of doctors not on the staff of the Hospital, to determine what could be done to put the Hospital in line for accreditation by the American Medical Association. The first step to this had to be a sponsorship by The Baltimore City Medical Society. Realizing the situation the Doctors Hospital was then in I wondered who had had the courage to make this bold request.

So it was at that time that I first met Dr. William Schuman, a man of medium physical stature, mild-mannered, intelligent, and, more to the case, willing and courageous enough to meet with us and accept our suggestions and advice in order to help the Doctors Hospital in any way that we thought best. Dr. Schuman told me later that when he accepted the position of Staff President he had decided to give it a trial for five years and that, if at the end of that time he had not been able to put the institution on an accredited basis, he would then resign.

Well, as we all know, our Committee helped to put the Board of Trustees on the right track and I can say, without fear of contradiction, that no one could, under such stagger-

ing obstacles, have done a more stupendous job than they did. The Doctors Hospital is today, largely through Dr. Schuman's superhuman efforts, a well regulated, well run hospital, fully accredited by the American Medical Association. The postgraduate courses alone are a tribute to his genius. In spite of the tremendous amount of time that Dr. Schuman has given to the Doctors Hospital he has also found time to be an active Staff Obstetrician of The Hospital for the Women of Maryland, and of the Sinai Hospital.

So much for Progress.

It was during these critical years that the Staff, the Board of Trustees, and the community had many trials and disagreements. However, a corps of loyal members of the Board of Trustees, led by Mr. Max Sokol, and of the Staff, led by Dr. Schuman, have now ridden the storm and reached a peaceful plateau with all working towards a common goal which could only have been the outgrowth of truly friendly relations with one another.

As I view the Doctors Hospital today I can truthfully say that they have an abundance of good physicians with the necessary aims and purposes to continue the high standards that have been developed during the past four or five years. Accreditation in residency training, except for that of the general practitioner, may take years to develop, but I feel that if the present interest of their own Staff and those specialists who are ever-willing to help continues, this residency training in general practice, at least, may not be too far off.

I cannot close without offering my sincere congratulations to the Board of Trustees and to the Medical Advisory Board who worked so diligently with those of us at The Baltimore City Medical Society to make the Doctors Hospital an accepted addition to our Baltimore hospitals which are so constantly and creditably functioning in the care of the sick.

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Baltimore, Maryland*



DOCTORS HOSPITAL



PHOTO OF A GROUP OF THE MEDICAL ADVISORY BOARD AND REPRESENTATIVES OF THE BOARD OF TRUSTEES
(DECEMBER, 1954)

Seated (left to right): ROSS Z. PIERPONT, S. J. VAN LILL, III, MR. MAX SOKOL (President, Board of Trustees), WILLIAM SCHUMAN (Chairman, Medical Advisory Board), BENJAMIN SARUBIN, CHARLES S. LEVY. Standing (left to right): EARL M. WILDER, JEROME SYNDER, EUGENE L. FLIPPEN, MR. DAVID B. SYNDER (Administrator), MR. P. E. RATCLIFFE, DONALD B. HEBB.

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ARTICLES OF INTEREST

HISTORICAL NOTES ON THE SITE OF DOCTORS HOSPITAL

GEORGE W. DE HOFF, M.D.*

The Mortons had decided to build a new home. While carrying the child destined to become Dr. Dudley Morton of Philadelphia, Mrs. Morton designed the house which later was built at 2724 North Charles Street. It was a well-designed and beautiful home, of massive brownstone construction, with inlaid hardwood floors in intricate patterns, and quartered oak woodwork outlining the large stairway of the central entrance hall. In those 1890's, Charles Street was unpaved, and above 27th Street the sidewalks were of boards laid lengthwise. The street itself was stony, and a veritable turnpike leading to Towson; at its upper end, a toll-gate was located at the intersection with Merryman's Lane, now University Parkway—here the traveler had to pay two cents to continue on to Towson. About 1909, Charles Street was graded and paved, the section above 29th Street filled to its present level, and the streetcars which had made their way up to 25th Street and St. Paul were re-routed across North Avenue, only recently re-named from Boundary Avenue.

It was in this suburban setting in early 1900 that Dr. James S. Barnard bought the Morton home and added a wing containing on each floor seven rooms and one service room, with a diet kitchen on each floor at the east end. Just back of the diet kitchen was an elevator, moving

by water power at the rate of about ten feet every minute, but it served. The barn was a noble one, and became the kitchen and the servants' quarters. Barnard's Sanitarium, it was called, and its bed capacity was 35, in 1906.



Photo of the author GEORGE W. DE HOFF, M.D. (right) and his son, JOHN B. DE HOFF, M.D., members of the Visiting Staff.

Dr. Barnard, a gynecologist and a skillful surgeon was graduated in 1882 from the Hahnemann Medical College, in Philadelphia. In 1905, he secured Dr. George W. De Hoff, of Baltimore, as his resident physician, and Miss Pearle A. Burling, of Rochester's Genesee Hospital, as his Superintendent of the Hospital and its school of nursing. Under their capable guidance, the reputation of this delightful little hospital grew rapidly, and attracted to its operating rooms such notables as the Doctors Bloodgood, Baer, Thomas Cullen, Holland, Winslow, and others. It was here that "Tom" Cullen characteristically

*Dr. George W. De Hoff represents the connecting link between the original institutions described herein and the Doctors Hospital which succeeded them on the same site. Dr. De Hoff, who has emphasized Obstetrics in his long medical career, was among the first to use the facilities of the new Doctors Hospital. At the present time he is still active as an Obstetrician at the hospital and is the eldest member of the Visiting Staff.

retorted to a colleague who had chided him for wearing old shoes when he operated, by replying, "I operate with my hands, Doctor, not with my feet!"

Fetterhoff (University of Maryland Medical School, 1885; Hahnemann Medical College, 1886) formed the Homewood Hospital. The School of Nursing was discontinued, and the



BIEDLER-SELLMAN SANATORIUM

In 1908, Dr. Barnard sold out to Dr. Hampson Hubert Biedler (University of Maryland Medical School, 1876) and Dr. William Alfred Belt Sellman (University of Maryland Medical School, 1872), two prominent Baltimore gynecologists. Almost immediately, they erected the brick back building, which, though greatly changed, is still standing. This raised the number of hospital beds to 100. Dr. De Hoff and Miss Burling continued in charge of the Biedler-Sellman Sanatorium until they were married, in 1911. (Dr. John W. De Hoff is their son.) Miss Julia Rebecca Hagenbuch, an honor graduate of the hospital's respected school of nursing, then assumed the position of Superintendent, which she held until 1921; Miss Hagenbuch is now a nurse in the Baltimore City Public School System.

Following the death of Dr. Biedler in 1921, a group of homeopaths headed by Dr. Ira Lincoln

hospital carried on until 1928, when it was sold to the Maryland Academy of Sciences.

These early institutions were well liked for their high standards of patient care. Although small from the viewpoint of today, comparison with its contemporary hospitals is of interest. The 1906 American Medical Association Directory lists the University Hospital, under the direction of Dr. A. M. Shipley, with a bed capacity of 35; the Hebrew Hospital and Asylum, with Dr. Charles Bagley, Jr. as superintendent, with 40 beds; the Church Home and Infirmary, Dr. T. D. Gavin as superintendent, with 135 beds; and the Johns Hopkins Hospital under Dr. Henry M. Hurd, and the Baltimore City Hospital, under the direction of the Sisters of Mercy, both with 350 beds each.

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HISTORY AND OBJECTIVES OF THE PRESENT DOCTORS HOSPITAL

WILLIAM SCHUMAN, M.D.

From 1928 to 1945, there is a hiatus in the medical history of the property on North Charles Street, which became a landmark in the city when the Maryland Academy of Sciences installed an astronomical observatory on its roof. In 1945, the Academy moved its activities to the Central Branch of the Enoch Pratt Library, and the property was acquired by a group of

purchased the property in 1945, and were duly licensed by the Health Department to operate a hospital following approval of the architectural plans. Building operations soon followed.

Thus opened the third chapter in the long and temporarily interrupted history of 2724 N. Charles Street as a hospital site. The original building which housed the first hospital on the property (Barnard's Sanatorium) fifty years ago was not fire-proof and was therefore demolished to make way for a new hospital building of modern construction, capable of accommodating 75 to 80 patients, and containing modern operating rooms, delivery rooms and nursery. The six-story building in the rear which had been built by Drs. Biedler and Sellman about 1909 as an addition to the original hospital (to which had been added the observatory) was a substantial well-built structure, and was left standing. It now houses the laboratories, pharmacy, record room, staff library-conference room, central supply, interns' quarters and a sun lounge on the 6th floor (which replaced the observatory).

The old operating room of the Biedler-Sellman Sanatorium and the Homewood Hospital, in which such notables as Baer, Bloodgood and Cullen operated, is a part of the present Doctors Hospital, being used as a library and conference room for the medical staff. The first educational venture of the new hospital, the M. Alexander Novey Lectures in Obstetrics, January to April, 1950 were held in that room.

OPENING OF THE NEW HOSPITAL— ORGANIZATION OF THE STAFF— OFFICIAL DEDICATION

The new hospital building was completed in 1947 and was opened to obstetrical patients in August of that year. Beginning in January, 1948,



DR. WILLIAM SCHUMAN

general practitioners, who were on the lookout for a centrally located site for a new hospital. This group of physicians, faced with a great increase in obstetrical patients occasioned by World War II, had been forced to use makeshift facilities for delivering soldiers' wives and war-brides as well as other pregnant patients because of the over-crowded conditions in our local hospitals. These general practitioners, incorporated under the name Doctors Hospital,

the hospital began admitting medical and surgical patients, and pathological and clinical laboratories were opened and staffed. The first meeting of the newly organized Medical Staff, presided over by the writer, was held on March 21, 1948. On May 4th of the same year, the Staff formally approved the new Staff Constitution and elected as its first officers, Dr. J. B. Culverhouse, president, and Dr. William Schuman, Chairman of the Medical Executive Committee. By the early part of 1949, clinical conferences had been established, with special emphasis on surgical pathology and critical analysis of the handling of surgical cases. On May 12, (Hospital Day) 1949, the official dedication of Doctors Hospital took place with leading medical, health, and municipal officials participating. Since that date, May 12th has been observed each year by the Staff and Board of the hospital with a Hospital Day Dinner.

THE M. ALEXANDER NOVEY LECTURES

In November, 1949, the writer of this chronicle, who, as Chief Obstetrician of the hospital, saw the need for a review course in Obstetrics for the general practitioner, asked permission of the hospital Board of Trustees to conduct such a course as a memorial to Dr. M. Alexander Novey, late Director of Maternal Hygiene of the Baltimore City Health Department. In that capacity Dr. Novey authorized the licensing of maternity hospitals in the city. It was through his insistence on the highest standards of maternity care and his recommendations in the architectural planning of the Obstetrical unit of the new hospital that those responsible for the creation of Doctors Hospital erected an institution of the most modern type. When the new hospital was officially dedicated on May 12, 1949, Dr. Novey, representing the Commissioner of Health, took an active part in the dedication exercises. Because of the assistance and encouragement he rendered on behalf of the new hospital in its planning stage, the Board of

Trustees gave their approval to a series of lectures as a fitting memorial to Dr. Novey.

The great success of the Novey Lectures (see article on "Postgraduate Education for the General Practitioner" in this issue) paved the way for the creation of the Postgraduate Institute at Doctors Hospital. The Board of Trustees of the hospital recognized immediately the great value of providing a means of postgraduate education for its staff members and any other interested physicians, and allotted a sum of money in its annual budget for that purpose. Reverend Leslie F. Weber, who is secretary of the Lutheran Home and Hospital Association, was a member of the Board of Trustees of Doctors Hospital when the Postgraduate Institute was created, and he was the Board's representative in laying the groundwork with the writer for the establishment of the Institute. He officially opened the first session of the Postgraduate Institute on May 13, 1952, exactly three years after the official dedication of the hospital. The Institute proved to be such an important activity of the hospital that a separate department was formed with a director as its head, comparable with the chiefs of the other major departments.

ADMINISTRATIVE REORGANIZATION

Since its official opening, many changes have taken place in the administration and organization of the hospital. Registration by the Council on Medical Education and Hospitals of the American Medical Association took place on December 1, 1952, following a survey of the hospital by an independent volunteer group headed by Dr. Ross Z. Pierpont, succeeded by a special committee of the Baltimore City Medical Society, whose chairman was Dr. Edward S. Stafford (see *Maryland State Medical Journal*, Volume 2, Number 4, April 1953, "The Role of the Baltimore City Medical Society in the Reorganization and Approval of Doctors Hospital"). During the period of reorganization the following steps were taken to meet local and

national standards of hospital administration: (1) The original founders were supplanted by a lay Board of Trustees (1948). (2) The original Administrator was replaced by the present one, Mr. David B. Snyder (June 1951). (3) A new Medical Advisory Board was appointed with Dr. William Schuman as Chairman (March 1952). (4) Mr. Max Sokol, who had led the negotiations with the Baltimore City Medical Society for the hospital, was elected President of the Board of Trustees (December 1952). (5) The original group of physicians who erected the hospital severed their connection (one of them died) with the institution. In 1954 a revised constitution was approved by the Medical Staff and Board of Trustees. The hospital had its first inspection by the Joint Commission on Accreditation in December 1954, and received notification of provisional accreditation in February 1955.

PRESENT FACILITIES

Many physical changes have been made in the new building as well as in the old one. When the hospital was built in 1947, the entire second floor was planned as a maternity section, but with the increasing vogue of early ambulation and short post-partum stay, it was possible to reduce the number of beds for obstetrical patients. Accordingly, of the two areas comprising the second floor, the north one was allocated to gynecological and other female patients, the delivery rooms were converted to pediatric ward. New labor and delivery rooms constructed on the south hall, with the nursery, now constitute a completely isolated maternity unit of 20 beds.

A modern cubicled pediatric unit of 5 beds and an adjoining ward of the same capacity provide the staff with facilities for sick children and children undergoing tonsillectomy.

The operating rooms are on the first floor, with an adjoining recovery room, completely equipped, for the care of 5 post-operative patients.

On the male hall, there is a separate cardiac ward for four patients with beds of special construction for expediting the care of cardiacs.

All accommodations are of the two-bed and four-bed type, there being no private rooms, unless a two-bed room is restricted temporarily to a single occupant (this is not encouraged).

A pre-natal clinic is conducted for non-private obstetrical patients, and also a well-baby clinic for the infants delivered on that service. Lack of out-patient facilities precludes the operation of medical and surgical clinics and the specialties (see *Plans for Future Expansion*).

The hospital was completely air-conditioned in 1956.

In the rear building, the old observatory of the Maryland Academy of Sciences was dismantled, and an entire new floor added, a modern daylight lounge, which was intended originally for patients. However, medical staff functions found this room to be particularly adaptable, and plans are now being drawn to enlarge the floor, which will be used as a staff library and conference room, large enough to hold the sessions of the Postgraduate Institute, now held in the cafeteria (capacity 70) and the present Conference Room (capacity 35).

PLANS FOR FUTURE EXPANSION

The hospital has acquired a large piece of property behind the present hospital building. It is intended to erect on that property one or more buildings for ancillary services, Out-Patient Department, added x-ray facilities and possibly a complete new obstetrical unit. With such an addition, re-adjustments will make possible the freeing of space in the Charles Street building for additional beds, sufficiently, it is hoped, to increase the bed capacity within the next two years from 85 to over a hundred. The maximum capacity contemplated for the foreseeable future is 150 beds. Also, in view of the increasing attendance at the sessions of the Postgraduate Institute, an auditorium, with a minimum

seating capacity of 100, may have to be provided.

OBJECTIVES

"Dedicated to the General Practitioner and his Patients," Doctors Hospital has taken a leading role in bestowing equal opportunity to practitioner and specialist, both in the admission of patients and in the organization of the staff, and it has pioneered in the establishment of a Department of General Practice in our local hospitals. (See article by Dr. W. A. Anderson, this issue.) Staff privileges, carefully screened by the Staff Credentials and Audit Committee and equally carefully acted on by the Executive Committee and by the Medical Advisory Board, are bestowed on the basis of training and experience. General practitioners are limited to the type of practice in which they have demonstrated proficiency. This policy is in keeping with the aims of the American Academy of General Practice, in which the American Medical Association concurs. Doctors Hospital intends to

continue to occupy its chosen place in the hospital community,—that of providing beds for the acutely ill patients of general practitioners and specialists alike, within its physical capacity to accommodate them.

From an educational point of view, Doctors Hospital hopes not only to continue but to broaden its postgraduate program for the special benefit of the general practitioner. It has no intention to offer graduate instruction in the specialties to house officers, but it definitely proposes to establish approved training programs for interns and residents in General Practice. At present this objective must be held in abeyance until a greater bed capacity is reached and facilities for out-patient care provided. With new construction planned for the immediate future, the entire educational program will rapidly move ahead, and with it the service to patient, doctor, and community will be greatly enhanced.

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ORGANIZATION OF A DEPARTMENT OF GENERAL PRACTICE AT DOCTORS HOSPITAL

WALTER A. ANDERSON, M.D.*

Today General Practice is an established separate and distinct department in many general hospitals throughout the United States. It is classified equally in rank with other departments of the hospital staff, such as Medicine, Surgery, Obstetrics, Gynecology, Pediatrics, etc., providing a voice for the general practitioner in the making and shaping of policies.

The annual census of hospitals, conducted by the American Medical Association in 1950, indicates that there were 1,654 hospitals with well organized General Practice departments.

*Chief of General Practice, Doctors Hospital; member, board of Directors, Maryland Academy of General Practice.

Another census taken in 1953 reveals 2,447 hospitals with similar departments,—an impressive record! Many of these departments are geared to a code of ethics and Rules and Regulations as outlined in the "Manual on General Practice Departments in Hospitals" which was prepared by the Commission on Hospitals of the American Academy of General Practice. The foregoing is recognized and endorsed by the American Medical Association and also by the Joint Commission on Accreditation of Hospitals.

During the past few years medical schools and university-affiliated hospitals, as well as

other large independent hospitals, have followed the example of the smaller metropolitan and rural institutions by establishing departments of General Practice. Locally, in 1955, the University of Maryland Hospital set up a department of General Practice, staffed by two full-time Residents. These two Residents rotate on a six month basis. One Resident serves in the out-patient clinics and rotates in all the special branches, taking full histories and performing complete physical examinations supplemented by all necessary laboratory work and x-rays. Those patients who are too ill to come back and forth to the clinic are admitted as in-patients for further observation and treatment. After serving six months in the out-patient department, he changes place with the inside resident and carries out regular routine hospital duties for service as well as private and semi-private patients.

PLAN FOR THE ACTIVE STAFF AT DOCTORS HOSPITAL

The Department of General Practice at Doctors Hospital was established in 1948 and was the first such Department organized in a Baltimore hospital. It is presided over by a Chief, who, by virtue of his position, is a regular member of the Executive Committee of the Active Staff, the Medical Advisory Board (consulting staff to the hospital and the Board of Trustees), and the House Staff Committee (composed of the Chiefs of all major departments). In addition, the present Chief of General Practice serves as a member of the Program Committee, which arranges for the speakers and material presented for the two bi-weekly clinical conferences held under the auspices of the Department of General Practice. Twice a year for a period of one month or more these conferences are incorporated in the sessions of the Postgraduate Institute. The Program Committee, which is actually the Educational Committee of the Department of General Practice, consists of three general practitioners in addition

to the Chairman, or Educational Director, who is also Director of the Postgraduate Institute. (See article on Postgraduate Institute this issue.) Thus, the educational needs and preferences of the members of the General Practice Department are maintained through the active participation of the department Chief and two other members.

In addition to the regular clinical conferences and Postgraduate sessions, which are held for the education of the staff members, regular bedside and chart room rounds are conducted by the Chief and members of the General Practice Department for the house staff. These rounds are held on patients that fall within the purview of General Practice (Medicine, surgical diagnosis and Pediatrics). Similar rounds are, of course, held in the specialties by the respective Chiefs of the other departments. By being on both the receiving and giving ends of the educational program, the Department of General Practice is geared to continuous professional instruction within the hospital's own wards and lecture rooms.

INDOCTRINATION OF THE HOUSE STAFF

At the Doctors Hospital the House Staff rotates on the various services, including General Practice. If a patient is admitted by a general practitioner, the case is assigned to the intern or assistant resident on Medicine and General Practice. If such a case is referred to a surgeon and thus transferred to Surgery, wherever possible the same house officer will follow the case. The philosophy of General Practice is stressed in the teaching of the House Staff, but interns showing special talent or adaptability are allowed to develop their preferences as to type of practice. However, the interns and junior resident give more time and attention to and receive more instruction in those departments concerned in General Practice,—Medicine, Obstetrics and Pediatrics. The entire House Staff, including the resident, are constantly impressed with the importance of a thorough physical survey of every patient admitted whether for a



FIG. 1

FIG. 1. PHOTO OF A GROUP OF THE STAFF TAKEN ON HOSPITAL DAY, MAY 12, 1954

Seated (left to right): W. H. MORRISON, I. W. TOWLEN, G. W. DE HOFF, C. M. KERR, W. A. ANDERSON, B. SARUBIN, J. BLUM. Standing (left to right): A. SCHIMEL, L. R. MASER, H. G. SUMMERS, W. SCHUMAN, H. W. SCHEYE, R. WEINBERGER, A. A. WEINSTOCK, L. T. LEVY, J. KUDIRKA.



FIG. 2

FIG. 2. HOSPITAL DAY (MAY 12, 1955) DINNER

Participants in the program—from left to right (men): MR. DAVID B. SNYDER, Administrator; MR. MAX SOKOL, President, Board of Trustees; MR. RALPH B. MURPHY, Executive Director, Hospital Council, Inc.; DR. RUSSELL A. NELSON, Medical Director, Johns Hopkins Hospital; DR. CHRISTIAN RICHTER, President of Staff (1955). Standing—DR. A. A. WEINSTOCK, Chairman, Committee on Arrangements; DR. WILLIAM SCHUMAN, Chairman, Medical Advisory Board.

simple hemorrhoidectomy or a radical mastectomy. In 1955, a novel and successful experiment was attempted in which members of the House Staff acted as office assistants in the offices of several of the general practitioners on the staff. Due to the increased demands in the hospital for the services of the House Staff, this plan had to be discontinued. The place of General Practice in the scheme of Medicine is daily stressed in every possible way by those responsible for the education of the House Staff.

SUMMARY

1. Reports by the American Medical Association show a steadily increasing number of Departments of General Practice in American hospitals.

2. The University of Maryland Medical School is one of several medical schools with a Department of General Practice.

3. The Doctors Hospital Staff, organized in 1948, was the first local hospital with a Department of General Practice.

4. The Department is administered by a Chief, who has equal status with the Chiefs of other major departments.

5. The Chief of General Practice is active in the educational activities of the staff, being a member of the Program Committee (including the Postgraduate Institute), which consists entirely of General Practitioners with the exception of the Chairman (Director of the Postgraduate Institute).

6. General Practice Staff conferences are held twice a month, and in addition, General Practice rounds for the House Staff are held regularly, all with general practitioners presiding.

7. The philosophy of General Practice is emphasized in the educational program of the House Staff, and House Staff assignments are geared heavily to General Practice.

CONCLUSIONS

The profession can be pleased with the history of growth and progress of General Practice in the organization of hospitals and medical schools.

It can be clearly and definitely stated that a well-organized Department of General Practice in a modern general hospital has a real place, and lends itself to proper administration and education of staff members and house staff, as

well as to the maintenance of good relations between the general practitioner and his associates on the hospital staff.

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POSTGRADUATE EDUCATION FOR THE GENERAL PRACTITIONER

WILLIAM SCHUMAN, M.D.*

Before the American Academy of General Practice was formally organized and, therefore, before its program of postgraduate education was launched, an event took place at Baltimore's youngest and smallest hospital that was destined to lay the groundwork for an entirely new concept of postgraduate teaching for practicing physicians. On January 11, 1950, Dr. Louis Douglass, Professor of Obstetrics at the University of Maryland Medical School, opened a series of thirteen lectures in obstetrics as a memorial to Dr. M. Alexander Novey who had recently passed away. (See "History and Objectives of the Present Doctors Hospital," this issue.) The small conference room, converted from the old operating room of the Homewood Hospital, which seats a maximum of 35 was overflowing with more than 50 physicians to hear Dr. Douglass. The astonishing fact about this unique event was that a hospital that had opened its doors but two years previously and had not yet gained recognition by the American Medical Association was conducting a postgraduate educational feature entirely new in the medical history of Baltimore, and was attracting physicians many of whom had never previously heard of Doctors Hospital. This apparent hunger for postgraduate courses and the stimulus soon to be provided by the organization of the Ameri-

can Academy of General Practice and its membership requirements made it clear that the average physician, whether a member of a hospital staff or not, was looking for a means to further his educational opportunities.

Accordingly, the idea of a Postgraduate Institute for the general practitioner was born, and as described in the History of the Hospital, the Board of Trustees of Doctors Hospital authorized a formally organized Postgraduate Institute and named the author as its Director. The first course under the auspices of the Institute was in the spring of 1952. Cardiology was the subject, the program consisting of a series of three evening panels, twelve afternoon lectures divided into six sessions, and five demonstrations in electrocardiography. Included in the lectures were one on physiology, one on pharmacology and two on pathology. The panelists and lecturers were members of the teaching staffs of the University of Maryland and Johns Hopkins Medical Schools, who gave their services gratis and who, following the precedent set by the lecturers of the Novey series, willingly left their clinics and laboratories to come to the Doctors Hospital to teach. The writer takes this opportunity publicly to acknowledge the great contribution made by those splendid teachers, and also by the large number of both full-time and practicing physicians who have given their time during the

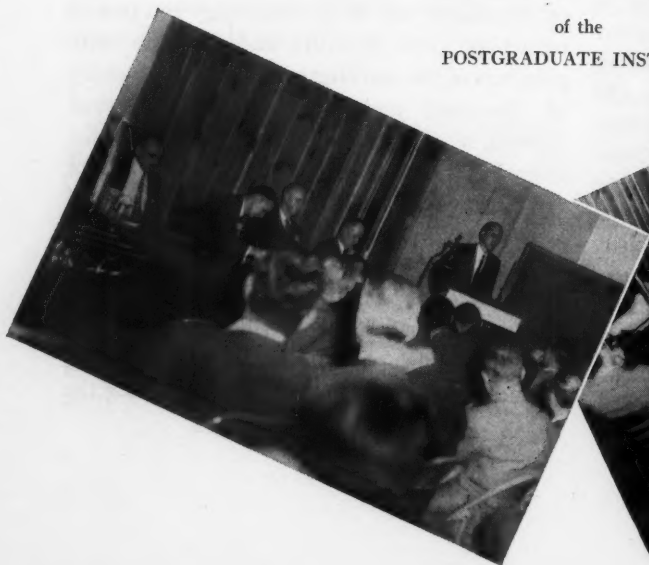
*Founder and Director, Postgraduate Institute, Doctors Hospital.



VIEWS OF SOME SESSIONS



of the
POSTGRADUATE INSTITUTE



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past five years to further the education of the general practitioner.

ATTENDANCE AND FEES

In the early years of the Institute, considerable experimentation had to be carried out in all phases of the new program, and the matter of fees was one of the areas of trial and error. Experience of others as well as that of the writer shows that charging a modest fee helps the attendance, on the theory that if one pays he will justify his expenditure by attending and not permit bad weather, fatigue, or a favorite television program to serve as an excuse for going or staying home. Based on the psychological fact that a service, like a commodity, is more highly valued when it is tagged with a price, the Postgraduate Institute charges nominal fees for its courses. These are kept to a minimum, averaging about five dollars for a ten-hour course. The lowest fee was three dollars for Proctology, the shortest course. The highest fee charged has been ten dollars for the courses of more than six sessions or longer than ten hours (Cardiology and Industrial Medicine). The exception was Pediatrics, when five dollars was charged for an 18-hour course. House officers from any hospital are not required to pay. The fee-exempt privilege has also been extended to physicians in the military forces, Veterans Administration, local and state Health Departments (full-time), and physicians just starting in practice. Registration in advance is required,—a practice calculated to boost attendance and give information as to the size of the audience expected.

The number of physicians attending the courses has been most gratifying. Panel discussions held at night have shown the largest attendance, and subjects related to the heart and blood vessels have been the most popular. In the Fall of 1955, a panel on "Disorders of Blood Coagulation" was so well attended that the cafeteria with an absolute capacity of 70 was bulging with 80 physicians, in addition to the four panelists and the chairman. The panelists were Doc-

tors Milton S. Sacks, John C. Krantz, Jr., H. Raymond Peters, and Arthur L. Haskins,—all Professors at the University of Maryland Medical School. The average attendance at the evening sessions (panels) has been about fifty, and at the mid-day roundtable discussions, thirty-five.

Of a total of 79 physicians in attendance at the Tenth Session held during the month of November, 1956, sixty-one were practicing physicians, two were dentists, and sixteen were interns and residents of several of the local hospitals. In addition to the sixteen house officers, three registrants were fee-exempt. Seventeen of the registrants were not connected with Doctors Hospital; 62 were members of the Visiting and House Staffs. Of 61 practicing physicians, 45 were general practitioners, 11 were Internists, and 5 were other specialists.

THE MASSACHUSETTS POSTGRADUATE INSTITUTE

In the summer of 1954, the author paid a visit to the offices of the Postgraduate Institute in Boston, which is under the auspices of the Massachusetts Medical Society. The Institute (established 1951) is a separate corporation with its own Board of Directors and a very dynamic Executive Director, Mrs. Charlotte Troutwine. Affiliated with it are the three Boston medical schools, the major Boston hospitals and Clinics, organizations like the Heart Association and the Cancer Society, and other Foundations. It holds sessions in Boston and elsewhere throughout the state. Its offices are in the building occupied by the Massachusetts Medical Society (there is no Boston Medical Society) and the New England Medical Journal. This office contains a complete file of courses, films, lecturers, mailing lists, and other data that has made the Postgraduate Institute there a clearing house for postgraduate programs available in the entire state. Bulletins are sent out regularly to subscribers. The corporation is tax-exempt and its financial position secured by grants from the Medical Society and several Foundations and Pharmaceutical labo-

ratories. The Institute in Boston has a fixed schedule of fees for its courses of one dollar and fifty cents per hour of instruction. A course of twenty hours in Massachusetts costs each registrant thirty-five dollars, compared with ten dollars at our institution. The Boston lecturers are paid an honorarium, based on mileage from Boston.

The President of the Postgraduate Medical Institute is appointed by the Board of Directors, which comprises ten physicians elected by the Massachusetts Medical Society. The man who has held that position since the Institute was established is Dr. Laurence B. Ellis of Boston, who is recognized for his leadership in that form of medical education.

PHILOSOPHY OF MODERN POSTGRADUATE EDUCATION

Dr. Ellis has published his experience and views, and his "Reflections on Postgraduate Medical Education for Practicing Physicians"¹ contains facts and opinions that should serve as a guide to everyone interested in the subject. His ideas so closely parallel those of the writer, that I have selected some of his observations to quote below.

"In the first place education should be part of the daily life of the physician, not a special event like a holiday. Therefore, *it must be brought to him.* (italics mine) . . . Full time courses lasting weeks to months at medical centers are not the answer . . . for teaching general medicine . . . Few can afford the time and money to take them. *The best way of bringing medical teaching to the doctor's own doorstep is to develop in the community hospital an approximation of the teaching hospital.* (italics mine) . . . Providing the educational opportunities on their home ground is helpful since it makes it easier for all to attend . . . A modest fee is reasonable if the medical teaching is good. Most physicians are opposed to hand-outs."

The modern era of postgraduate teaching owes

its beginning to the regional plans of medical service, the first of which was the Bingham Associates Program, organized in New England in 1931, and which was followed in 1946 by the Rochester (N. Y.) plan. In the past five or six years, several similar projects in different parts of the country have been established, the purpose of which is to send special skills and services from the large medical center to the outlying areas. The idea has done much to help neutralize the damaging effects of the concentration of professional and technical talent in the great urban medical centers. Lecturers, conferences, and rounds given by imported clinicians with a teaching background constitute one facet of this multi-sided program to assist the small hospital in maintaining a high professional level.

Locally, Doctors Hospital has, in effect, merely copied the idea by putting itself in the position of the small rural hospital and soliciting the teaching institutions of Baltimore of their experts in the various specialties as voluntary instructors. The magnanimous response of the many individuals requested to talk has already been noted. (Strangely enough, the only refusals came from the distaff side of the profession—three or four women physicians were not in sympathy with the project and asked to be excused.) Until very recently there was no official policy by the medical schools in Baltimore with regard to unaffiliated neighboring hospitals. However, within the past few months those of us directly interested in providing postgraduate opportunities for hospital staffs and other physicians were highly gratified to receive a memorandum issued by the Johns Hopkins Medical Institutions in May, 1956. In a statement of policy, the Johns Hopkins Medical School, Hospital, and School of Hygiene and Public Health are prepared "to approve the participation of the Johns Hopkins Staff in the educational programs of other hospitals . . . ; and to conduct occasional postgraduate programs for physicians from Baltimore and the surrounding communities . . ." Both the Johns Hopkins Institutions and

the University of Maryland have pursued this policy even without an official memorandum to that effect, and the Doctors Hospital has been the most consistent beneficiary of that policy.

FACTORS IN THE SUCCESS OF THE PROGRAM

Remembering Dr. Ellis' words, let us examine some of the other factors in the success of the postgraduate program at Doctors Hospital. Doctors Hospital is conveniently located in the heart of Metropolitan Baltimore. Physicians practicing in the various residential areas within the city, on the fringe, and in county communities (Essex, Dundalk, Glen Burnie, Pikesville, Towson, etc.) find it to their convenience to come to a hospital as centrally located as Doctors Hospital for an hour or two before or after office hours. The ability to park a car within a block of the hospital without parking restrictions is an added inducement. The same physicians have a feeling of being "at home" in the small hospital, but feel rather ill at ease in the vastness of the large teaching centers. In the large institutions the timing of programs is of necessity influenced by the schedules of teachers and students, as well as the activities of the house staff, whereas in a small institution like Doctors Hospital the convenience of the general practitioner is the primary consideration. For example, no teaching center would schedule a 2-hour panel discussion as late as 9:30 p.m. At Doctors Hospital our evening sessions begin at that time and last until 11:45 p.m. A midnight snack is served to encourage the audience to stay to the end and thus avoid the distracting departures during the latter part of the evening. As with any program, close attention to small detail for the accommodation of registrants may spell the difference between a highly successful and a disappointing result.

The content of each session is carefully planned so that it will be attractive to the generalist. In keeping with the action of the A.M.A. Council on Medical Education and Hospitals in dropping the classification "re-

fresher" course, emphasis is placed on recent advances in diagnosis and treatment. Courses are limited in length (six or eight sessions) to avoid lagging of interest toward the end. Particular care is exercised not to include boring statistics, unintelligible slides containing minute data, or other material of interest only to a specialized group. Straight didactic lectures are avoided, and if any basic science material is necessary for the understanding of the subject under discussion, it is interspersed with clinical presentations. This has been very successfully accomplished in arranging panels where there are four speakers, one of whom may review the basic physiology, chemistry, or pharmacology necessary to good comprehension of the entire subject. For example, a panel on steroid medicine included a series of slides showing the chemical structure and metabolism of the various steroids. Of course, there have been many panels where no basic material had to be presented. Another form of presentation that has proven very popular is the round-table discussion where one or two discussants informally give their clinical experiences. Participation by the audience in questioning the speakers often provides the querying physician with a possible solution to a puzzling diagnostic or therapeutic problem in the handling of a current patient,—in itself a form of consultation. This feature of the Postgraduate sessions is most attractive to the average practitioner and possibly explains his preference for the smaller hospital over the large teaching institution as the environment for his continuation studies, for unquestionably, he is more reticent about participating in the discussion in the strange atmosphere and austerity of the large teaching center.

THE LOCAL PICTURE

In spite of the lack of an adequate auditorium and the absence of financial support from organizations like those in Massachusetts, the Doctors Hospital has maintained a comprehensive postgraduate program for general practitioners, the

like of which has not been offered by any other hospital in Baltimore (and in fact, Maryland). In May, 1957 the Institute will have completed its fifth year of consecutive operation, and this gives it the distinction of being the oldest and most sustained local program exclusively for the education of the general practitioner. The Medical and Chirurgical Faculty of Maryland, of course, has been holding its annual meetings for many, many years, and it may be considered a postgraduate course, but it is not held exclusively for general practitioners, and it is not a continuous program. The Postgraduate Institute antedates the clinical sessions sponsored by the Maryland Academy of General Practice, held regularly several times during the year in different places in the city; it also preceded the courses which were given for a short time by the Baltimore City Medical Society and which were discontinued because of poor attendance. It is to be hoped that the Basic Science review course given at the University of Maryland Medical School for physicians preparing for the State Board examinations will be resumed after being suspended for the time being. Church Home conducts a very successful course in Electrocardiography once each year. Mercy Hospital has held a course in Obstetrics and Gynecology for the past few years. A recent postgraduate day at Baltimore City Hospitals, sponsored by the Academy of General Practice, was excellently conducted by the hospital staff chiefs, but of the almost filled lecture room only twenty-five comprised the visiting delegation of practicing physicians, the remainder of the audience being composed of medical staff, house staff and nurses. Judging from the local experience, one would conclude that in the Baltimore area the major effort should be directed toward encouraging programs at the smaller hospitals rather than at the teaching centers. If other Baltimore hospitals followed the example set by the Doctors Hospital in organizing formal postgraduate courses, a central coordinating agency would have to be created to avoid

repetition and competition,—both enemies of any successfully integrated local program.

OFFICIAL APPROVAL

Members of the Maryland Academy of General Practice are given credit toward their postgraduate hours requirement for attendance at the Doctors Hospital Institute's sessions. The courses of the Institute are officially recognized by the Council on Medical Education of the American Medical Association and are listed in the official Educational Bulletin of the Council. Complete reports on attendance are forwarded to the Council at the completion of each program. Doctors Hospital is one of a small group of independent "non-teaching" hospitals throughout the country that offers formal postgraduate instruction under officially approved auspices.

SUMMARY

1. With the birth of the American Academy of General Practice, because of the membership requirements for postgraduate study, there has been a recent stimulation of interest in continuation courses for the special benefit of the general practitioner.

2. The M. Alexander Novey Memorial Lectures in Obstetrics held at the Doctors Hospital in 1950 provided the spark from which the idea of a Postgraduate Institute for general practitioners was born.

3. The Postgraduate Institute of Doctors Hospital, founded in 1952, held its first session in May of that year. Since then it has been in continuous successful operation. It is the "oldest" institution formally organized in the Baltimore area offering instruction by means of continuous sessions exclusively for general practitioners.

4. As many as eighty (80) physicians have attended its sessions. Evening panels draw a larger attendance than daytime discussions.

5. Nominal fees are charged to stimulate registration and regularity of attendance.

6. The Massachusetts Postgraduate Institute (established 1951) is cited as a model organization for the conducting of postgraduate courses, and its president, Dr. Laurence B. Ellis, is quoted because his views are applicable in our instance.

7. The small community hospital is the logical place to serve as a center for postgraduate courses because of convenience to the general practitioner, and for psychological reasons.

8. Teachers and clinicians of the local medical schools and large teaching hospitals render exemplary and unselfish service by acting as panelists, lecturers, and discussants at the Postgraduate Institute of Doctors Hospital without pay.

9. The policy of the Johns Hopkins Medical Institutions (expressed in a written memorandum) and that of the University of Maryland (in practice) serve as a great stimulus to those engaged in a postgraduate program like that of Doctors Hospital.

10. The American Academy of General Practice approves the courses of the Postgraduate Institute of Doctors Hospital for credit hours applied to the membership requirement of members of the Maryland Chapter who attend. The courses are registered with the Council on Medical Education and Hospitals of the American Medical Association.

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APPENDIX

LIST OF SESSIONS OF THE POSTGRADUATE INSTITUTE

First Session:

May-June, 1952, "Diseases of the Heart."

Second Session:

October-December, 1952, "Diseases of the Upper Gastrointestinal Tract."

Third Session:

April-May, 1953, "Endocrinology in General Practice."

Fourth Session:

October-November, 1953, "Proctology for the Practitioner."

Fifth Session:

April-May, 1954, "Industrial Medicine and Traumatic Surgery."

Sixth Session:

November, 1954-February, 1955, "Latest Advances in Treatment."

Seventh Session:

April-May, 1955, "Pediatrics in General Practice."

Eighth Session:

October-November, 1955, "Recent Advances in Medicine and General Practice."

Ninth Session:

May-June, 1956, "Common Female Problems in General Practice."

Tenth Session:

October-November, 1956, "Recent Advances in Medicine and General Practice."

Scientific Papers

FATAL CANDIDIASIS AND *PS. AERUGINOSA* SEPTICEMIA IN A FETUS AS A RESULT OF ANTIBIOTIC THERAPY¹

Report of a Case

WALTER KOHN, M.D.²

Generalized fungus infections, systemic moniliasis and disseminated candidiasis are synonymous terms which have appeared in the literature of the past few years (1, 2, 3). Evolving from a status heretofore considered rather benign and innocuous in nature, these infections have assumed a stature of a most dangerous and serious form necessitating an understanding on the part of the clinician as to their etiology, pathogenesis, prevention and treatment.

By definition, moniliasis is a term used to designate any infection caused by any species of monilial organism (4). There are many strains of monilial organisms and the specific one with which we are concerned and the one which we encounter in our practice is the fungus known as *Candida Albicans*. The term Candidiasis has been applied to this specific infection (5).

Candida Albicans is a saprophytic fungus which is a common inhabitant of the skin, nails, gastro-intestinal tract, oral cavity and the female genital tract. Under normal conditions infections caused by this fungus were treated very competently on the part of the profession. Although they were capable of producing a variety of metastatic visceral lesions as a result of the invasion of the blood stream (6, 7, 8).

With the advent of penicillin during the past decade and later on with the introduction of the broad-spectrum antibiotic drugs to our

chemo-therapeutic armamentarium, increasing reports have been accumulating in the literature of cases of candidiasis of a localized and generalized nature, producing lesions involving the integumen as well as the gastro-intestinal, broncho-pulmonary, genito-urinary, cardio-vascular system, and even the central nervous system with fatal outcomes in many of the cases (9, 10, 11, 12, 13, 14, 15, 16, 17, 18).

When these secondary monilial super-infections began to manifest themselves in the dawn of the antibiotic era, very little attention was paid to them and they were considered an annoying situation complicating therapy which only necessitated withdrawal of the drug. A more serious situation ensued in recent years when, in addition to the spectre of moniliasis, a highly resistant form of gram-negative bacillary infection involving organisms of the proteus vulgaris, coli-aerogenes and pseudomonas groups of germs and a highly insensitive antibiotic resistant strain of staphylococcus emerged as a result of therapy with the newer drugs (19, 20, 21, 22, 23, 24).

The following is a case report of the transmission of both a gram-negative organism (*Ps. Aeruginosa*) and a monilial germ (*Candida Albicans*) transplacentally to cause the death of a fetus in utero as a result of antibiotic treatment of an intercurrent infection in the mother in the last trimester of pregnancy. Insofar as can be determined from the literature, this is the first report of a death in utero as a result of antibiotic therapy.

¹ Presented at Phi Lambda Kappa Interium Scientific Meeting, Miami Beach, Florida, April 4-12, 1956.

² From the Department of General Practice, Doctors Hospital, Baltimore, Maryland.

CASE REPORT

A 42 year old Rh Negative female, grav. 5, with four children living and well, had her last menstrual period on February 28, 1954, giving her an E.D.C. of December 6, 1954. Her past history was not remarkable, having no complications or sequelae following her 4 previous pregnancies. She gave no history of previous miscarriages or premature labors, nor did her Rh negativity predispose to any complications in her previous births.

On September 18, 1954, the patient developed an acute upper respiratory infection characterized by drenching sweats, high temperature, chills and marked prostration. Her temperature reached a peak of 104.8°. Examination disclosed areas of patchy consolidation in the bases of both lungs in addition to the usual findings of an upper respiratory infection. She was given 600,000 units of procaine penicillin intra-muscularly and received a total of 2,400,000 u orally over a period of two days without any marked change in her condition. She was then given 100 mgm. Aureomycin intra-muscularly and 250 mgm. orally every 6 hours over a period of four days, receiving a total of 4 gms. of the drug. This therapy resulted in a subsidence of her infection with a clearing of her lungs. She was apparently well one week after return of her temperature to normal. During this siege, except for severe backache, she had no complaints referable to her pregnancy. Her blood pressure and urine examinations were normal and fetal movement was apparent to her all through the period of her illness.

On October 19, 1954, three weeks following her recovery, she discovered an absence of the usual fetal activity and felt as though she were carrying a heavy weight in the pit of her stomach. This was not reported to the doctor and on October 24 she went into spontaneous labor and a dead fetus was delivered. On admission to the hospital, she had a temperature of 101.2°, pulse 100, and B.P. 128/85. Fetal heart sounds were absent and the temperature was thought to be due to absorption of toxins of the dead fetus. The labor itself was not remarkable, the 1st stage lasting 9 hrs. 50 min., 2nd stage 1 hour, 50 minutes and 3rd stage 10 minutes. The placenta on delivery revealed numerous patchy yellowish-brownish necrotic areas. The patient became afebrile following delivery and was discharged from the hospital 4 days following her delivery in good condition. An autopsy was performed on the fetus 14 hours after its delivery.

AUTOPSY REPORT

The body was that of a well-developed 7 month male fetus, wt. 3 lbs. 4 oz., height 40 cms. from vertex to toe and 30 cms. from vertex to buttocks. Body heat was absent and there was postmortem hypostasis with partial disappearance of rigor mortis. The skin was blotchy over

the face, upper part of the arms and upper chest. The scrotum was edematous and infiltrated with fluid. On opening the body cavity, the liver was markedly enlarged, extending to the umbilicus with numerous thin fibrinous adhesions in the peritoneal cavity. The anterior surface of the liver was studded with numerous yellowish areas 1-3 mm. in diameter. There was approximately 10 cc. of free peritoneal fluid. Cultures of the liver were made and inoculated in brain broth and a small piece of liver was also placed in brain broth. There was a thin sub-fusion of blood in the scalp muscles, and the brain tissues were soft without gross lesions. The fontanelles were well-formed. The lungs floated in fixing fluid and were dark purple and fully expanded. The thymus gland, heart and lymph nodes were not remarkable. The liver was very enlarged as well as the spleen. The former extended across the abdominal cavity and overlaid the latter. There was marked engorgement of the liver and sectioned surfaces were swollen, containing yellowish areas extending into the parenchyma. The adrenals showed hemorrhage into the medullary portion. The kidneys were enlarged, the sectioned surfaces of which were dark purple in color.

Gross anatomic diagnosis: Septicemia.

Microscopic Examination:

Smears of the liver and exudate and bloodculture revealed gram-negative bacilli identified as *Ps. Aeruginosa*. Microscopic examination of the liver showed the pulp markedly engorged with numerous polymorphonuclear leukocytes in the peri-portal areas. There was an acute phlebitis of the portal veins. Engorged sinusoids and miliary abscesses were scattered throughout the parenchyma with the presence of numerous colonies of bacilli. In addition there was present in the blood cells and the blood vessels a network of pale-staining fibrils which appeared to be mycelia of *Monilia Albicans* and the same fibrils and Easter organisms were found scattered throughout the abscesses of the liver. These were later identified as *Candida Albicans* by culture. There was no evidence of greenish-yellow pigmentation which one usually sees with *Ps. Aeruginosa* infection. The adrenal glands showed scattered areas of necrosis and cellular exudate in the medullary portion. The lungs showed areas of atelectasis with small air spaces, and engorged capillaries in the septa. The peritoneal surfaces of the intestines were edematous and infiltrated with inflammatory cells and polymorphonuclear leukocytes; the gall-bladder showed marked autolysis with thickened wall and veins infiltrated with inflammatory cells. Pale-staining fibrils of mycelia of *Monilia Albicans* were prominent in all the vessels of the brain and the Virchow-Robinson spaces contained numerous lymphocytes with scattered polymorphonuclear cells. Small foci of inflammatory cells

were scattered throughout the brain and the area near its base.

Microscopic diagnosis: *Ps. Aeruginosa* Sepsis, Candidiasis, Multiple Liver Abscesses.

DISCUSSION

Although not universally accepted as a cause of Candidiasis (25, 26), it is felt by many clinicians and investigators that the administration of antibiotic drugs does definitely predispose to the development of resistant monilial and bacterial infections. A warning as to this possibility was given a few years ago (27).

In the case of the new-born, there exists a definite relationship between infantile and maternal moniliasis and the maternal source appears to be the principal avenue of infection. During pregnancy there is definitely an overgrowth of monilial organisms in the genital tract (28, 29) and under normal circumstances placental invasion of these germs is rare, the infection manifesting itself usually in the localized terrain of the female tract. In the new-born the infection is manifested by involvement of the mucous membranes of the oral cavity in the condition known as "thrush" and also by infection of the skin, most notably around the genital and perianal areas. That a virulent germ can cause infection of a fetus through the placenta is a proven fact (30) and with the use of antibiotics a massive overgrowth of both monilial and bacterial germs is a possibility (31, 32).

Why do these resistant insensitive superimposed infections occur as a result of antibiotic therapy? The millennium was thought to have been reached in our war against infection with development of the drugs only to be faced with the stark realism that with their use highly resistant insensitive forms of infections have followed.

There are many theories as to the reason these monilial and bacterial germs gain the upper hand when antibiotics are administered. Some investigators assume that with the administration of these drugs an individual loses the ability to form immune bodies thus bringing about a

lowering of the resistance of that person (33). Alteration of bacterial flora with a resultant overgrowth of monilial and certain bacterial strains is another explanation offered (34, 35). The presence of a debilitating disease with its concomitant avitaminosis resulting in an alteration of the normal vitamin-bio-synthesis that is required to maintain the bacterial flora in a normal state is another theory advanced (36, 37). This may be due to the presence of an excess of available nutritive substances which was denied these organisms in the presence of the normal flora. Finally, because of a lack of a growth-restraining substance normally present and produced by the flora, these germs are stimulated to further growth without any inhibiting factors to control them (38).

In retrospect, one must go back to the infection which was incurred by the mother in the beginning of her last trimester of pregnancy and consider the effects which therapy may have induced in the fetus. Alteration of the bacterial flora of the vaginal tract as a result of the administration of penicillin and aureomycin could have produced an overgrowth of both monilial and bacterial organisms of high resistance culminating in a virulent massive infection of the fetus through the placental barrier by contiguity. A combination of pathogens, *Ps. Aeruginosa* and *Candida Albicans* invading synergistically, played primary roles in producing a virulent and devastating form of bacteremia with sepsis and fatal outcome.

With the numerous amounts of antibiotics used in this modern medical age, prevention of these superimposed infections becomes an all-important matter. Attempts to prevent and treat these infections have been made by the use of acidophilus milk, buttermilk, and yogurt in order to keep the intestinal flora in a normal state. Vitamin B Complex has been prescribed in large doses to overcome the avitaminosis present in most of the cases. Combinations of large amounts of the components of B Complex have been incorporated with the antibiotics.

33). Injections of liver extract have been used. Recently a potent drug, Nystatin, to prevent and treat fungus infections, was introduced. Nystatin is compatible with all antibiotics, is considered the drug of choice in preventing and treating fungus infections complicating antibiotic therapy. The action of the drug is concentrated in the intestinal tract, although preparation for local use are available in the form of ointments, solutions and suppositories (39, 40, 41, 42, 43). Polymixin B is the drug of choice in treatment of *Ps. Aeruginosa* infections and very recently a new agent, Novobiocin, has been found to counteract the increasing incidence of resistant forms of staphylococcal infections. Magnamycin and Bacitracin are two drugs that are indicated in the treatment of certain gram-positive and gram-negative organisms that have proven resistant to penicillin and other antibiotics.

CONCLUSIONS

Ever mindful of the dictum—*primum non nocere*—it is mandatory that the clinician be aware of the fact that with the administration of antibiotic drugs, resistant and insensitive superinfections of fungus and bacterial origin may occur. These complications may be more serious than the original condition. There is a group of individuals in whom secondary infections may occur when given antibiotics.

1. The geriatric patient in whom bodily processes and immune responses are likely to be at low ebb and who in all probability is avitaminotic.

2. The premature and young infant in whom susceptibility to numerous infections is common because of lowered resistance and undeveloped antibodies.

3. The diabetic in whom because of disturbed metabolic functions cutaneous and vaginal moniliasis occur frequently.

4. The pregnant female in whom disturbance of the normal vaginal physiology increases the incidence of fungus infections.

SUMMARY

A case has been presented of the death of a fetus in utero caused by disseminated Candidiasis and *Ps. Aeruginosa* septicemia. The immediate cause of the combined sepsis most likely was the result of the administration of antibiotics to the mother in the beginning of her last trimester of pregnancy for the treatment of an intercurrent infection. It is believed that this is the first case of this kind reported.

The reasons why these superimposed infections occur are presented.

Specific prevention and treatment of monilial infections and therapy for superimposed bacterial complications are suggested.

ADDENDUM

Since the preparation of this paper for publication a new antibiotic, Oleandomycin, has been introduced to combat the incidence of superimposed staphylococcal infections resulting from established antibiotic therapy. This drug as well as Novobiocin has been combined with Tetracycline and penicillin in synergistic combination for increased efficacy.

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LETTERER-SIWE DISEASE

Report of a Case

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HISTORICAL

In 1924, Letterer reported an acutely fatal illness in a six month old child having the following characteristics: petechiae, lymphadenopathy, splenohepatomegaly and fever. Akiba and Borisawa (1903) independently described, but did not classify, a similar syndrome.

Siwe, in 1933, added a case and reported only four in the past literature. He tied them firmly into a clinico-pathological entity characterized by purpura, progressive anemia, normal or decreased leukocytes, normal differential and platelets, generalized adenopathy, hepato-splenomegaly, diffuse non-lipid reticulo-endothelial cell proliferation, acutely progressive fatal course, affecting infants and young children, not hereditary or familial in character.

Abt and Dennenholz reported similar cases coining the name Letterer-Siwe disease, and it has been suggested that this would be a more appropriate appellation for this syndrome.

Otani and Ehrlich (1940) simultaneously with Lichenstein and Jaffe described what the latter two call eosinophilic granuloma of bone. Since then, cases have been described relating Letterer-Siwe disease with Hand-Schuller-Christian disease and eosinophilic granuloma of bone.

Siwe and Lynch, et al., saw no justification in this relationship. They classified Letterer-Siwe disease as a malignant proliferation of reticulo-endothelial elements in the malignant lymphoma group to be differentiated from disseminated xanthomatosis often mistaken for the former condition.

In 1949, Hansen described five cases, drawing conclusions that Letterer-Siwe disease repre-

sented the first phase of gradual transition in the continuous development of a disease process leading to eosinophilic granuloma and to Hand-Schuller-Christian disease. The last, or fourth phase, ended in fibrous healing, and was regarded as the chronic and benign form. These were the cases which had apparently reacted to therapy and were regarded as cured. It is now generally believed that these so-called cured cases do not belong to the Letterer-Siwe group.

In 1953, Paull stated that the diverse manifestations of reticulo-endotheliosis were different phases of one disease. The clinical picture depended on the rapidity of the pathological process and the location of the lesions. Thus, the rapidly progressive and fatal cases were Letterer-Siwe, the chronic, eosinophilic granuloma of Hand-Schuller-Christian disease. The gradual transition from one to the other was observed.

Bierman, et al., in 1952, described a syndrome in identical twins which reacted favorably to aureomycin. Bony lesions decreased in size. An infectious component was suggested when, along with penicillin, both infants were well twenty-three months later, though sequelae remained and other evidences of residual disease were present.

Two recent articles sum up the situation most effectively: (1) Case 41151 from the records of the Massachusetts General Hospital, Benjamin Castleman, Medical Editor, published in the *New England Journal of Medicine*, April 14, 1955. (2) Non-lipid Reticulo-endotheliosis, in *Cancer*, January-February, 1955, by Alan C. Mermann, M.D., and Harold W. Dargeion, M.D. The latter do not agree with the unitarian theory because of the malignant nature of Letterer-Siwe disease, the lack of response to

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therapy, and the fact that no etiologic agent has been found.

CASE HISTORY

The patient recorded here is that of M.J.L., a 20 month old white male child who was born in 1953. Up to the time of his rapidly fatal illness, he developed in an average, normal manner. The child's mother first sought medical attention when he manifested what seemed to be a simple upper respiratory infection with fever, cough, and some anorexia of several days duration.

Physical examination at that time revealed a somewhat pale, but well nourished white male child. Temperature 101°. Rhinitis and a slightly injected posterior pharynx were present. A few small encrusted and vesicular lesions were noted on the scalp. The gums and buccal mucous membranes appeared injected and there was lymphadenopathy of the type commonly seen in febrile affections of children. No splenomegaly or hepatomegaly was noted at the time.

The child had a history of penicillin allergy and was placed on erythromycin and general supportive therapy. He was seen a total of five times over a period of ten days. There was not much change in the patient's subjective symptoms. His temperature during this period varied between 100.8° and 103°. A pediatric consultation was requested when the child failed to improve. There was a lapse of three days between the last home visit and time of hospitalization.

At the time of hospitalization on August 12, 1955, physical examination revealed the temperature to be 102°. The child appeared listless, pale and feverish. He had developed a discrete, hemorrhagic, vesicular, scaly rash over the entire body. In addition, he revealed generalized lymphadenopathy with marked splenomegaly and hepatomegaly. The gums were swollen and bled easily. There was posterior nasal mucous discharge; tubular breathing was noted. No other positive findings were noted.

Laboratory Findings

Urine

8/16/54—negative for albumin, sugar, and cellular elements.

Blood Studies

	HBG Gms.	%	Hct	WBC	PMN	Lymph.	Monos.	RBC
8/13	11.6	81	39	9,700	66	32	2	
8/18	10.7	74	36	10,400	57	40	1	
8/23	Platelets 160,000/cu. mm.—normal							
8/25	9.5	66						3,600,000
8/27	10.2	71	35	10,100	66	33	1	

Blood Chemistry

	Urea Nitrogen mg. %	Sugar mg. %	CO ₂ Vol. %	Chlorides meq/L	Na meq/L	K meq/L
8/13	8	90	40	106		
9/1				105	132	4.3
9/2				96	125	5.4

Spinal Fluid

	Sugar mg. %	Protein mg. %	Aggluti- nation	Pandy	Cells
8/18	70	45.6	0	0	0

Bacterial Cultures

8/18	Blood	Alpha hemolytic streptococcus
	Spinal Fluid	Negative
	Nose	Streptococcus, Staphylococcus
	Throat	Non-hemolytic Streptococcus
9/1	Blood	Negative

Heterophile Agglutination

8/16	Positive	1:7,	1:14
	Negative	1:28,	1:56

Course in the Hospital

Following admission, the above laboratory studies were done. As noted, these revealed only a mild anemia. X-rays of the chest, long bones, and skull were essentially negative. A biopsy of a lymph node taken from the right groin revealed inflammatory reaction with fibroplasia at the periphery. The architecture appeared preserved. A skin biopsy revealed histiocytic invasion and many fibrocytes. The child was placed on terramycin and aspirin plus supportive therapy. He continued to have a persistent spiking fever reaching 105° to 106° at times. There was frequent nausea and vomiting and eventually abdominal distension. Cortisone therapy was tried, but did not appear to affect the course of the disease. The child became progressively worse and on September 5, 1955, respirations became shallow and rapid. His air passages became obstructed with mucus and he was suctioned and placed in an oxygen tent. The following day he became markedly cyanotic and had a sudden large hemorrhage from the nose. Cedilanid was administered, but the patient lapsed into a coma and expired on September 6, 1955.

No post mortem was obtained.

USUAL POST MORTEM FINDINGS

The following data is a composite of the usual post mortem findings, as determined by a re-

view of a number of case reports. All of the following findings, however, need not be present to categorize this condition. The information should be regarded as a composite picture.

Skin. Extensive dermatosis. The lesions may appear to be small papular and purpuric in type, eventually becoming confluent and encrusted with final excoriation, oozing and ulceration. The lesions may involve all parts of the trunk and extremities, and, in addition, can extend to involve the external auditory canal, gums, oral mucous membranes. The palpebral conjunctivae have been seen to be erythematous, with large punctate lesions.

Lymph Nodes. There is generalized lymphadenopathy, also involving the mesenteric and retroperitoneal nodes. Microscopic examination usually reveals extensive histiocytic and lymphocytic infiltration with replacement and destruction of the normal architecture. Active phagocytosis of red blood cells is usually seen.

Liver. Hepatomegaly is marked and post-mortem findings reveal that the normal architecture is completely destroyed. The periportal lymphoid elements are almost completely replaced by very large aggregates of reticulo-endothelial type cells. The Kupfer cells appear hypertrophic and may be in the process of detachment.

Spleen. Marked splenomegaly is noted with large areas of focal necrosis. The reticulo-endothelial cells dominate the picture with destruction of normal architecture. Perifollicular hemorrhage is common. The sinuses are usually dilated and packed with histiocytic elements. A notable reduction in the size and number of malpighian follicles may be seen.

Bone and Bone Marrow. Inflammatory lesions of the bones may be seen. These are usually large soft lesions causing expansion of the bone. The lesions appear microscopically as massive numbers of histiocytes arranged in sheet-like collections. These osteolytic lesions may be seen in any of the bones, but are usually seen in the long bones and calvarium. The bone marrow

reveals practically complete replacement of the normal constituents. Dominating the picture is the presence of massive numbers of large actively phagocytic histiocytes containing injected red blood cells.

Heart and Lungs. At autopsy the pleural cavity has been seen to contain large amounts of blood stained fluid. Subpericardial hemorrhage have also been noted, but no other striking cardiac findings are usually seen.

ETIOLOGY

The etiology of Letterer-Siwe disease is unknown. It has been assigned to the following three categories:

- A. Infectious
- B. Neoplastic
- C. Metabolic

In our opinion, the neoplastic school of thought is the most convincing. Lichtenstein prefers to call the whole series Histiocytosis, believing Letterer-Siwe disease, eosinophilic granuloma and Hand-Schuller-Christian disease to belong to the same family.

Differential Diagnosis: Here, too, three categories can be described: A. Skin. B. Lung. C. Spleen, lymph and blood organs.

The skin conditions to be ruled out are Ritter's disease or dermatitis exfoliativa neonatorum. In this disease, the onset is late, with desquamation in large sheets, leaving raw areas. Lerner's disease or erythrodermia desquamativa, can be considered, but is quickly ruled out in the absence of exudates, red skin, frank scaling and a family history of allergy. Impetigo usually starts on the face or buttocks. Epidermolysis bullosa congenitiva starts at birth and is located on knees and elbows, leaving raw areas. Syphilis is excluded by a Hinton Test. Lesions are usually present at birth, are more brawny, desquamate, and occur about the mouth and anus. Infantile eczema, the most difficult to rule out, usually exists on the face and scalp rather than the trunk. In general moniliasis of the skin, organisms can frequently be cultured from the

lesion. Thus, the lesion described in the above case fits the Letterer-Siwe description.

Lung disease, as such, may be eliminated by x-ray study in the aspiration type of pneumonia or tuberculosis. The absence of an organism rules out generalized moniliasis; the S.T.S., syphilis. The well-nourished appearance of the child precludes pancreatic fibrosis or congenital agammaglobulinemia; the absence of family history, Jewish heritage and central nervous system degeneration eliminates Niemann-Pick disease. Therefore, by the presence of Letterer-Siwe cells infiltrating into the terminal bronchioles, plus emphysema and cystic formation, the Letterer-Siwe label may be applied.

Finally, we must consider the disease producing generalized visceral involvement such as spleen, liver, lymph nodes and blood elements, along with storage diseases. Leukemia can be eliminated by bone marrow studies and absence of lung involvement except in eosinophilic granuloma. In lymphoma, the lesions are more spread from the hilus. Gaucher's disease produces central nervous system symptoms and bone lesions. Niemann-Pick disease presents a cherry red spot in the macula. Letterer-Siwe disease, on the other hand, causes the liver and spleen to become enlarged; anemia is not uncommon. Biopsy of the skin and lymph nodes reveal the true diagnostic picture.

DIAGNOSIS

The criteria for a diagnosis of Letterer-Siwe disease are listed as follows:

1. Marked splenomegaly and hepatomegaly;
2. Hemorrhagic tendency: petechia and purpura;
3. Generalized glandular enlargement with discrete non-tender nodes;
4. Localized bone tumors showing rarefactions (five or eight cases show no bony change);
5. Secondary anemia, progressive and of non-regenerative type, appearing late in the disease, with normal or diminished white blood cells;
6. Moderate fever;
7. Non-hereditary or familial tendency;

8. A pathological picture of generalized hyperplasia of the reticulo-endothelial system;

9. Onset acute and unrelated to infection with a rapidly fatal course;

10. Occurrence in infants and young children.

TREATMENT

No known treatment has proven effective. Empirical methods are employed. ACTH has been most effective in temporarily staying the progress of the disease. Cortisone has shown a similar action. Nitrogen mustard is less effective and aminopterin least of all. Some reports suggest a cure with antibiotic therapy, emphasizing the infectious nature of the disease. The work of Mermann and Dargeon negates the presence of an offending organism or virus. Supportive therapy in the form of vitamins and blood transfusions is, in the main, administered.

SUMMARY

A case of Letterer-Siwe disease (syndrome) is reported. This rapidly fatal condition, occurring in infants and young children, is classified as a neoplastic process involving the reticulo-endothelial system, particularly the non-lipid variety related to eosinophilic granuloma and Hand-Schuller-Christian disease. It is our conviction that these three conditions are one and the same pathological process. The picture changes only with respect to the age of the patient and the duration of the disease process.

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THE PHYSICIAN AND THE OVERWEIGHT PATIENT¹

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We are here concerned with the patient, who following an adequate history and physical examination, is about to be placed upon a weight reduction program; this may be the result of physiologic or cosmetic embarrassment, and may have been suggested by the physician or requested by the patient.³

From the first, as in actual clinical manage-

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³ For discussion of the experimental, etiologic, metabolic and other important aspects of obesity, referral is made to certain excellent review articles (1-4).

ment of any patient, it is imperative that the attitude of the physician be one of utter sincerity. Too often the obese individual is met with jokes or other levity which are effective only in his discouragement, and possibly in the increase of some sense of guilt. Intuitively, this obesity is of great concern to its owner, and automatically he will often express this by self-ridicule or by a seeming lack of concern. Do not be misled into the adoption of a similar attitude; emotional material of a very sensitive nature is often casually handled in public, as witness attitudes to marriage and religions.

If the patient appears to be diffident or unnaturally casual, one must insist that he recog-

nize the gravity of this situation in order that the corrective approaches recommended may more easily be followed. This will be easier if the obese person is at the same time afflicted with some more obviously organic pathology, such as diabetes mellitus, hypertensive cardiovascular disease, or osteoarthritis. If the obesity has been the result of a neurotic adjustment, without the disorders suggested above, the physician's task is difficult in its delicacy, for many cling tenaciously and without easy understanding to their hyperphagia, or are torn from it only to suffer other emotion trauma, or perhaps to clutch at another neurotic defense. The wiser physician will not coerce the resentfully reluctant.

Furthermore, the prospect of some future ill health or decreased longevity is of little worth in the deterring of a patient, just now moderately comfortable in his obese refuge. There is a marked lack of general interest in life insurance statistics among those who would benefit most from the evidence these data present. Energy is wasted in warning a healthy fat person of what may happen to him in the next decade or so.

Full cooperation and encouragement of the family is of much help; its members should be reminded that obesity is a sickness and that return to a more nearly normal weight is a return to health. Too often, the thinned features or wrinkles sometimes associated with the withdrawal of fat depots results in unwise comments linking weight with health, or loss of weight with sickness.

Many patients will ask, "Doctor, how much should I weigh?" This is best countered by inquiring about the weight they would prefer, or the weight at which they have felt best, or their weight before marriage or as a young adult. These last have an advantage in having existed at one time for this patient, and therefore can more easily be accepted again. Modern man has a strong desire to meet the so-called normal standards, and as these only occasionally coincide with personal preferences, a conflict is introduced which could otherwise have been avoided. It

may help to remind certain patients of the uselessness or non-existence of hats or shoes of "normal sizes." An exact weight should only rarely be suggested by the physician as a target to shoot for, and the patient may even need cautioning against setting a goal beyond probable attainment. For our professional guidance, various tables are available, as well as easily remembered formulae for the determination of approximately proper weights for given personal statistics; likewise, formulae are available to prognosticate rates of weight loss, but these rarely match clinical performances, and may serve to discourage some patients. One may impress upon the obese individual that his "target weight" has been his own choice, that it can be attained if rationally chosen, and that it may be changed if later consideration warrants. The presence of an active disease process may require that the physician more nearly dictate the amount of weight to be lost.

Imperative, at this initial consultation, is the rejection of what is commonly called "will-power" as being an effective force in a weight reduction program; indeed, this just makes official what the patient already knows! He is reminded that will-power is difficult to define, and said by some psychologists not to exist; certainly, if it is the ability to stick to a distasteful course, then he is like all other human beings in having not enough to work with. One soon realizes when will-power is lacking, and then reasons that there is no use in further attempting a diet program which seems to require this factor for its success. The entire regime is then discarded, often with great sense of relief. Will has been defined as "the ability to make a choice" (5), and accordingly any will "power" applied to a reduction diet would imply a veritable parade of decisions at each meal between what seems to be wanted, and what has been said to be "good for one." This results in a fatigue state of the will, with failure to respond to repeated stimuli, or rebellion manifested by the diet's discard.

A motivation which is more nearly automatic

in its operation must be supplied to patients, and must be described in terms which can easily be understood and ably utilized. "Desire power," is a term I have found to be most helpful in the instruction of patients in their diets. Inscribed on signs in the dressing rooms of college and professional football teams, desire has been stressed as a driving force for these rugged individuals, and has helped spell success in their campaigns. We all are willing to work hard, to endure personal privations, and to submit to rigorous limitations in order to gain a desired goal. Patients must be reminded of their own strivings for what they sincerely wanted, such as education for self or children, or establishment of savings or insurance programs. If their choice is to reduce, their desires must accordingly be consciously increased for such things as trimmer figure, increased agility and suppleness, and greater comfort of movement.

Here can be driven home the need for a positive approach to dieting. One gets an increase in power, achieves a new and nicer look, attains freedom from annoying symptoms, secures greater ease of mobility. The improvements to result from a diet regimen are to be stressed by both patient and physician. A sense of permanent renunciation should not pervade the temporary shelving of rich foods which are desirable for reasons of taste or customs of entertainments; these are to be considered as luxuries, and in common with other similar pleasures are subject to well-disciplined indulgence at appropriate times.

The loss of physical mass sometimes must be presented as a desirable procedure, for it represents an elimination of a useless drag, the removal of a handicap. The euphemism, "weight change" may even be substituted for weight loss. To the larger male patients, this is of great importance, for many of these have unconsciously substituted physical mass as a replacement for the waning of physical powers which insidiously appears after the third decade of life—and resist this loss of size with great vigor.

This natural tendency to associate mass and power finds expression in such sayings as "throwing his weight around," and "he carries a lot of weight with the boss," but here merely serves to increase the usual disproportion between body weight and muscle strength, which becomes more apparent as one grows older (6). These once powerful but now obese men can sometimes be persuaded to increase their strength relatively, by the trimming of their bodies to a neater and more agile organism. Our grandfathers said, "A lean horse for a long chase"; even now, these horses are shod with aluminum shoes for racing, every extra ounce being an admitted handicap.

The increased alertness of a more active body, coupled with diversion of aggressive drives from oral satisfactions, frequently results in enhanced business or social relationships; this evolves more easily if the patient is so advised that he consciously directs this transfer of aggressions from food to other environment. Failure to develop suitable targets for normal aggressive drives may otherwise result in increased irascibility.

Finally, the patient is reminded that he alone is responsible for adherence to the diet to be prescribed. Although this concept is usually superficially accepted, it is occasionally rejected in several hidden ways. A wife will say, "My husband works hard and I have to cook a big meal for him, and then watch him eat it." A husband will reluctantly agree that, "If my wife will fix it for me, I guess I'll follow the diet." A child will offer the excuse that, "I come from a fat family." And the office worker will complain that, "I can't get this kind of food where I eat." Upon a return visit, an opening remark may be, "Doctor, you are going to be mad with me, because I haven't stuck to my diet." Each patient must firmly understand his responsibility as a mature adult, for adherence or nonadherence to diet instructions, and for the securing of additional equipment or family compliance necessary to gain the goal sought. Further, he should be urged to discard any feeling of guilt connected with defections—having accepted

responsibility for the dietary deviation, he must then assume the further responsibility for the taking of those steps which will rectify the situation.

A trap exists for the patient and physician who begin to discuss food intake in the relative terms of "too much," "just enough," or "not enough." It may help to point out that if one watches another's savings account, it is not necessary to know how much he makes and how much he spends to know which is the greater. The patient, accordingly, is cautioned to watch his weight as an accurate measure of the difference between energy input and energy output; as in any budget, the balance is the tip-off to excesses. One exception to this is the collection of water which irregularly occurs in body tissues as body fat is eliminated (7), or which may be an edematous complication of underlying disease; the former will take care of itself as the reduction of weight proceeds, and undue sodium restriction or the use of diuretics is thought to be of little value. Edema of pathologic states may be managed as required by the basic disease process.

Reassured by a serious and friendly attitude on the part of the physician, and armed with two well-known, easily understood and frequently used concepts of desire and personal responsibility, the patient is now introduced to a diet. Many reducing diets of varied construction are easily available, both from professional sources and from the popular periodical press. All have in common a lessened calorie content, no matter how greatly they differ in preparation or presentation. Any limitation of calorie content below the basal requirement level for the individual will result in a loss of weight, but this achievement may be of little value if the physical status suffers from nutritional deficiencies inherent in an unusual diet. The admonition to secure a well-balanced diet seems trite, but the current popular success of one diet which has stressed free intake of high protein foods, another offering an equally liberal intake of carbohydrates, one even with a high fat content (8),

and still another which is completely liquid, should be enough to revive this caution. A correct reduction diet should furnish a variety of foods with adequate vitamin content, and above all should teach the patient the composition of a proper diet. This last attribute is not found in the unusual diets referred to. The physician should at least read well the diet he is prescribing, and should actually follow it for a short time, so that it is familiar to him. Each modification will so progressively alter the original diet formula that it ultimately becomes ineffective; for this reason, only those changes specified by the physician, may be made. All that is offered should be eaten, and nothing used which is not listed. Many obese individuals profess to the omission of breakfast, it is commonly noted, and the consumption of this meal is to be stressed; earlier rising may be needed, and this will afford time for waking-up and better composure. Encourage the eating of the entire noon meal. The mid-afternoon snack is occasionally included, in order to avoid reaching the evening meal hungrily nervous and urgently downing large portions. In the later evening, television creates a passive spectator state where tensions cannot easily be dissipated by speech or action. Snacks at this time are often excessive, and low-calorie foods for nibbling may be included in the diet. Some individuals can be persuaded to turn their passive receptive state into an active interest in hobbies or group activities. As obesity is both a cause and a result of some additional degree of passivity, or the spectator role, a change in any of these factors may well affect the others.

As for the diet itself, a total calculated content of 800 calories is just about right, as this affords about 1000 to 1100 calories intake at the table. For hospitalized patients at bed rest, a 500 calorie diet is required; this should contain almost 1 gram of protein per kilogram of body weight. Ample experience has shown that a diet of 450 calories results in but a negligible nitrogen loss for the obese person, as he can

mobilize his fat stores for energy (9, 10). Such a diet may occasionally offend sensibilities of dietitians, but always proves satisfactory to patients who have become seriously obese. Even diets of water only can be well tolerated for a week or so, if urgency of reduction is sufficient. Calculated calorie contents of 1200 or over are useless for weight reduction, for their content after preparation at home without accurate measures is sufficient to slow weight loss to an unsatisfactory rate.

For prescription purposes, one may use a more or less individualized typed format, or may avail himself of the many diets prepared and printed by various commercial agencies. These latter often display a biased composition, which may or may not be suited to modifications, but have an advantage in being not only well balanced, but neat or interesting in their presentation. Popular magazines frequently publish reducing programs; occasionally these are poorly balanced, and designed for extremely short-term usage, sometimes under medical supervision. Others, upon closer examination, will be found to closely resemble any good diet that the physician proposes, and are mentioned here as a reminder that diet composition may vary widely, but calories must be at a certain minimum to insure weight loss.

The selected diet can then be introduced as an instrument for the patient to use in the fashioning of a new figure, and as a tool it can be a pleasure to use, though enjoyment was not its primary intent. Unless there are urgent medical reasons to reduce, it may be understood that occasional deviations are permitted. Rather than be an object of pity or misunderstanding at parties or holidays, the patient may eat moderate portions of what is being served, although this may defer success or require greater effort after the festivity.

Calorie-counting, or the selection of foods by the patient on a basis of calories alone as found in various booklets, is not feasible. Most obese individuals are not sufficiently interested in the

extra effort required. The diets so assembled may indeed be low in calories, but also may be very unbalanced in the other nutritional elements. Unfortunately, there is a tendency to consider items of high calorie content to be "good food," while lower calorie foods are of lesser desirability. The dressing-up of diets with no-calorie spices and seasonings is to be encouraged, as any weight-changing diet must be palatable and enjoyable if its pursuit is to be maintained. Various carbonated beverages are available, sweetened without sugar or not sweet, as the dry quinine-water "tonics," which are of value at parties. These may help when the patient finds himself saying, "I'm hungry, but I don't know what to eat!" If he is truly hungry, any food will be welcome; such indecision in choice of snacks should warn the patient to search behind his appetite for its nervous source, and then attempt to manage that restlessness without deviation from the diet.

Many medicinal preparations are available to assist the dieter in his new venture, and are familiar to physicians through active sales promotions. Most contain a type of amphetamine, many include a sedative, and a few some bulking agent or mixture of vitamins; some cortical stimulants are not related to the amphetamine group. Any of these may be effective, perhaps partly though a placebo effect; side effects from any of the component drugs may be expected, and are to be minimized in significance, or by reduction of dosage. Sedatives alone may be quite effective in those instances where tensions or anxieties are great. Some patients prefer to diet without medications, and their wishes should be respected. It is a sound practice to personally control the use of these drugs by the dispensing of sufficient tablets at each office visit, just as injectable medications are dispensed by all physicians; this minimizes the casual use of these drugs, and almost eliminates their prescription by telephone. Effective combinations of recognized anorexigenic drugs are available, so coded by colors as to be easily

managed by the patient. A perpetuation of so-called official denunciation of these combinations should be stopped by referral to the original article (11) which was directed not against the medications, but against an advertising technique. Desiccated thyroid substance is of dubious value and may or may not be used; it is the general feeling of investigators that it is of no value in the weight reduction of euthyroid individuals (12). Certainly, its use from the start makes later detection of thyroid dysfunction difficult. Various hydrophilic colloid preparations or bulking agents, some in the form of confections or crackers, have been advocated. Abdominal distention and uncomfortable fullness may result, but more important is the adverse psychological effect of catering to a trait which is in the process of being curbed, that of over-eating. A good diet will provide foods for snacks which will be more effective, less expensive, and which fit into existing eating norms. An adequate vitamin supplement may be prescribed for those whose weight loss continues for more than four weeks; these should not contain folic acid, unless definite evidence indicates its propriety.

Every effort should be made to bring each patient to a realization of the importance of his attitudes toward eating, and help must be given to develop those which are favorable. The physician should choose a diet and a few anorexigenic compounds so that he may become skilled in their use; neither he nor the patient should ever consider a tablet or a diet as the most important phase of a reducing program. Adjuncts they are, and as such they should be offered to the patient. Dieters may consider them as crutches, to be used gratefully, and then discarded when no longer of need.

Return visits are conveniently scheduled at intervals of two weeks. This allows time for sufficient weight loss, and experience with the dieting to serve as background for further discussion. Pertinent physical examination is always performed at this time, to keep the

physician aware of physiological adjustments. Further considerations of emotional and physical reasons for obesity may be discussed, and means of adjusting to individual problems suggested. Return visits are decidedly not merely to weigh a patient and dispense more medicine; such routine procedures could as well be accomplished by a druggist's assistant. The patient must benefit from each visit by a better understanding of his former or decreasing obesity, and will profit by being helped to develop a new concept of alimentation. Such patient education requires many visits, with an opportunity to investigate other emotional problems which would not at first have seemed of importance. Group therapy along these lines has not been proven of value (13). When the patient has demonstrated his desire and ability to adhere to any prescribed regimen, he may be allowed to return at four week intervals, but never at longer intervals. At all return visits the physician's attitude must be one of honest interest in the patient's progress. Inability to adhere to a diet must not result in its abandonment—by either party, because of frustration or anger. Any given course may be changed at reasonable intervals, and one must be willing to accept a certain percentage of failures. Sarcasm, scolding, or scathing comments have no place in the management of any sick person, and especially in obesity, where guiltiness and resentment are so easily brought from their lurking places below the emotional surface. Recurrences of obesity are frequent (14). If blame or fault for this is ascribed to or assumed by the patient, subsequent management becomes more difficult.

Reducing diet and medication may be discontinued when the patient has achieved the target weight. He is then instructed to observe his weight at regular intervals, and never to wonder why weight is gained, but rather why or when enough food was eaten to cause such an increase. A variation of three pounds over or under the target weight is allowed. Free but unindulgent choice of food is permitted, with a

return to the diet when and if a chosen upper limit of weight is exceeded.

If a dietary regimen has been properly supervised by the physician, and seriously followed by the patient, the latter will have acquired a new habit-pattern of eating, and such a delight in the physical freedom from excess fat, that relapse into obesity is slight and short-lived.

SUMMARY

The following factors in the management of the overweight patient are stressed:

1. The attitude of the physician must be one of utter sincerity.
2. Warnings as to the effect of obesity on longevity are useless.
3. Full cooperation and encouragement of the family is of much help.
4. Let the patient choose his own "target weight."
5. Motivation of the patient should be based on "desire power," rather than "will power," the exercise of which often results in a fatigue state.
6. The patient should be made to understand that he alone is responsible for adherence to the diet, but should be urged to discard any feeling of guilt connected with defections.
7. The eating of breakfast and the entire noon meal should be encouraged, so that the evening meal is not hungrily devoured.
8. A total calculated diet of 800 calories affords about 1000-1100 calories actual intake.
9. Diets can be reduced to 450 calories with but a negligible nitrogen loss.
10. The use of anorexigenic drugs should be controlled by the dispensing of sufficient tablets at each office visit.
11. Desiccated thyroid substance is of dubious value.

12. The physician should see his overweight patients every two weeks and should do more than merely take the weight and dispense drugs. Pertinent physical examination should be performed, emotional factors discussed, and means of adjusting to problems suggested.

13. Sarcasm, scolding and scathing comments have no place in the management of obesity.

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GENERAL ANESTHESIA—A PREFERRED METHOD

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In perusing the history and development of anesthesia we find that innumerable agents and techniques have occupied prominence for varying periods, only to be relegated to oblivion after prolonged clinical appraisal.

Those anesthetic agents which have stood the test of time and which have survived the age both of empiricism and scientific scrutiny are Nitrous Oxide, Ether, the Barbituric Acid Derivatives and Cyclopropane.

I. NITROUS OXIDE

Nitrous oxide, combined with oxygen, is still a very popular anesthetic agent, but if used alone, it is necessary to increase the amount of NO_2 above eighty per cent, and the danger of hypoxia in order to get to plane one of the surgical stage is a seriously objectionable feature of this practice. It is often employed in the gas, oxygen, ether sequence, or in conjunction with intermittent doses of pentothal. If the latter method be employed considerable amounts of pentothal are needed to maintain the patient in the surgical stage. Post-operative somnolence is prolonged and anesthesia is not nearly as satisfactory as when it is used in conjunction with cyclopropane.

II. ETHER

The popularity of ether is waning. The criticisms and disadvantages of this agent are mounting steadily. This may come as a surprise to those not intimately involved in the day to day vicissitudes of anesthesia practice.

The disadvantages of ether are many. It produces a shift in the acid base balance, lowers the pH, alters liver and kidney function, which may or may not be evanescent. It promotes vomiting and nausea and delays post operative

recovery. In children it is difficult to maintain an even plane of anesthesia with the danger of vomiting and aspiration of gastric contents ever a hazard.

Hershey reported that:

"ether may produce acidemia, fluid imbalance, interference with carbohydrate metabolism and of itself brings about many of the circulation disturbances characteristic of shock. Often patients do not look normal despite comparatively high blood pressures. They withstand blood loss poorly and their response to transfusion is delayed and inadequate."¹

III. EVIPAL AND PENTOTHAL

Evipal, the original ultra short acting barbiturate, was introduced by Weese and Scharpf in Germany in 1932. This drug because of its freedom from initiating laryngeal spasm has been staging an amazing comeback after years of pentothal supremacy. Furthermore, a recent scientific appraisal of both drugs indicated that there are fewer electrocardiographic changes incident to the use of evipal⁴.

It is generally agreed that pentothal is not an anesthetic per se and should not be employed as such⁵. It is merely an induction agent to be used to produce momentary unconsciousness after which anesthesia is produced and maintained by employing gaseous or liquid anesthetics or mixtures of them. Not only is pentothal not an anesthetic, but it is hazardous in the extreme both from the standpoint of initiating laryngeal spasm and the danger of overdosage.

A new barbituric acid agent, Neraval Sodium gives promise of being preferable to both pentothal and evipal as an induction agent. The danger of initiating laryngospasm with this agent seems to be very greatly minimized and recovery from it is extremely rapid.

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IV. CYCLOPROPANE

Cyclopropane, by comparison with ether, was evaluated by Virtue et al². Rats were anesthetized with ether or cyclopropane and then given irreversible shock. In observing the survival time it was found that those animals receiving cyclopropane lived longer than those receiving ether.

For cardiac surgery and poor risk patients with recent coronary heart disease and other types of cardiac pathology who must undergo surgery, Etsten of Tufts³ has demonstrated that light cyclopropane anesthesia is far safer than ether, and that the arrhythmias associated with cyclopropane occurred only when high concentrations of that agent were used.

In 1948 Shane⁶ demonstrated that by rendering a patient momentarily unconscious with evipal or pentothal, followed by the administration of a mixture consisting of ten per cent of cyclopropane (it requires from 20 to 25 per cent to produce and maintain surgical anesthesia) plus forty-five per cent each of nitrous oxide and oxygen and using a *semi-closed* absorption system, he could maintain predictable, light, non-fluctuating plane one surgical anesthesia for an indeterminate number of hours without danger of overdosage, and that this mixture could be used on the poorest risk patients for any type of surgery. Since its introduction eight years ago, some minor changes in technique have been made and it is now known as the S-A or the Shane-Ashman method of anesthesia^{7, 8}.

A similar mixture has been used in England for years by John Bullough⁹. He employs the "withdrawal method" for elimination of the expired gases from the operating theatre.

The S-A method does permit some cyclopropane to escape into the atmosphere, with each exhalation, and for good reasons. With the patient blowing off the expired gases into the room through the open exhalation valve and not re-breathing his own breath (as he would in a *closed-system*) he can much more efficiently dissi-

pate excess heat, moisture, and most important of all, carbon dioxide. The retention of this gas which is difficult to overcome when employing a *closed* system can be extremely dangerous.

Young and Seely¹⁰ proved that by faradically stimulating the vagus nerve in an animal whose carbon dioxide tension was normal, even in the presence of complete anoxia, cardiac arrest could not be produced. But in an animal whose carbon dioxide tension was elevated, faradically stimulating the vagus nerve even in the presence of high oxygen tension would produce cardiac arrest.

Virtue² further demonstrated that carbon dioxide excess weakens the heart beat and produces arrhythmias.

Dripps¹¹ demonstrated that the insidious build up of carbon dioxide which occurs in a *closed* system inevitably results in volatile acidosis, lowered pH and elevated blood pressure. Removal of the mask after prolonged anesthesia when this system is used may result in a precipitous drop in blood pressure, often to shock levels after the patient leaves the operating theatre and blows off the accumulated carbon dioxide. Dripps called this phenomenon "cyclopropane shock."

The closed system of anesthesia long heralded as the *only* method by which cyclopropane should be administered should be condemned for additional reasons.

Baumgarten¹² demonstrated that water is formed when carbon dioxide unites with the soda lime (which is supposed to absorb all the carbon dioxide). Humidity in such a system may rise to such levels that it interferes with the vaporization of water resulting in a rise of body temperature. This in turn increases the amount of water the gases will hold causing a relative lowered concentration of oxygen in the inspired air.

It has been suggested by Cole¹³ that decreased water loss through the lungs, kidneys and skin may cause cerebral edema and failure to regain consciousness.

It must be obvious that the *semi-closed* or non-rebreathing system which is used in the S-A method is unquestionably more physiologic since it permits the continuous elimination of carbon dioxide, heat and moisture and therefore more efficiently maintains hemostasis by assuring a normal pH, pulse, blood pressure and respiratory rate.

Many enthusiastic reports on the preference of this method of anesthesia have come from other parts of this country and abroad.

Samuel Lieberman¹⁴ of the University of Buffalo School of Medicine recently reported the use of a similar method of anesthesia for thirty-five hundred tonsillectomies in children.

Shane and Ashman^{7, 8} have employed this method at the Lutheran Hospital of Baltimore in over twenty-five thousand patients without a fatality due to anesthesia.

Greenwald¹⁵ et al, employing this method in obstetrics reported that:

"if for no other reason than the virtual elimination of vomiting during anesthesia induction and maintenance, the S-A method would have earned its place as our anesthetic of choice for Obstetrical delivery."

Greenwald also compared the breathing and crying time of infants born after saddle block and the S-A method. He concludes that there is very little difference between the two, the saddle babies being thirteen per cent more active.

When this method was first announced it was criticized rather severely by anesthesiologists¹⁶ who claimed that cyclopropane should be used in a *closed* system only and that any method that permitted this gas to escape with each exhalation into the operating room as it would in a *semi-closed* system constituted an explosion hazard.

As a consequence this mixture was tested by Dr. George Thomas, Professor of Anesthesiology of the University of Pittsburgh School of Medicine and consultant to the United States Bureau of Mines, and Dr. Sylvan Foreman of the United States Industrial Chemical Corporation of Baltimore. The opinions of both of these experts are

that the mixture is explosive but no more so than other commonly used anesthetics, including ether. Dr. Thomas stated that the presence of nitrous oxide in the mixture dampens and diminishes its explosive and flammable range and further, that as the patient exhales the mixture through the exhalation valve the eighty per cent of nitrogen in the surrounding atmosphere renders the escaping gases non-flammable and non-explosive. It is safe therefore to use the cautery or X-ray units up to within eighteen inches of the exhalation valve.

In lung, esophageal and cardiac surgery no sparking or electrical apparatus which may generate a spark can be used in the chest with this method since the entire thoracic cage is an explosive area once the chest is opened and the lungs exposed. Dr. Thomas further stated:

"open or semi-open technic will provide some safety against rupture of the trachea and lungs should an explosion occur. We have learned of several violent explosions that resulted in only minor burns and the surgery was continued. Some of the anesthetists were using Ayres' T tube or Stephen and Slater valves. The violence of the explosion in each instance was released through the open portion and so was not transmitted to the patient's trachea or lungs. Therefore it appears to me that safety factors of real value become available when the open technique is employed. It is true that spillage of anesthetic vapors will occur in anesthetizing areas but today this is no great problem since hospitals have provided adequate ventilation in the operating and delivery rooms. I realize that the cost of the anesthetic agents will be increased by this technic but the surgical room is not necessarily the best place to practice economy"¹⁸.

The outstanding advantages of the S-A method of anesthesia can be summarized as follows:

1. Extremely rapid induction and return to consciousness even after prolonged anesthesia.

2. Paucity in the incidence of hypercapnia, post-operative shock and atelectasis.

3. Less nausea and vomiting than is the rule after the use of other general anesthetic methods.

4. Freedom from the danger of anesthetic overdosage due to the persistence of an even, non-fluctuating plane of anesthesia.

5. Safest anesthetic method for the poorest risk patient regardless of age or operation if general anesthesia is to be employed.

6. Less fluctuation in pulse and blood pressure than that seen with any other type of general anesthesia during and after its administration, providing fluid and blood loss are adequately replenished.

7. Less explosive than any anesthetic combination which contains ether as an ingredient.

The S-A method of anesthesia has been used for the past few years at Doctors Hospital to the exclusion of all other methods when general anesthesia is employed for general surgery and obstetrics. It is remarkably reliable and simple to administer. In obstetrical cases for obvious reasons the evipal or pentothal induction is not employed as these agents traverse the placental barrier in about four minutes and exert a depressing effect on the respiratory center of the infant. Demerol and scopolamine are used instead to produce amnesia before the gases are administered.

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UNCOMPLICATED PREGNANCY AND DELIVERY IN A SMITHWICK-OPERATED PATIENT

CHARLES M. KERR, M.D.,¹ AND A. A. SUSSMAN, M.D.²

In the treatment of hypertension, the present vogue leans heavily toward the use of the ganglionic blocking agents and other blood pressure reducing drugs, rather than toward surgery. However, operation may be definitely indicated in selected cases, particularly where response to drugs has proven unsatisfactory because of unsustained lowering of blood pressure, syncopal attacks, bladder dyskinesia and obstinate constipation with recurrent episodes of fecal impaction.

The case of a 23 year old primigravida, who had a bilateral Smithwick thoraco-lumbar sympathectomy in 1949, is of interest because of the uneventful pregnancy, labor and post-partum course six years following operation.

CASE HISTORY

Mrs. B. J. H., age 23, white, married, para 0-0-0-0.

F.H. Father and maternal grandmother had diabetes mellitus. Patient is a twin, as was her maternal grandmother. An identical twin is living and has no history of hypertension.

P.H. Usual diseases of childhood, including scarlet fever, uncomplicated. In June 1949 patient was admitted to the Charles S. Wilson Memorial Hospital, Johnson City, New York, with the complaint of severe hypertension, throbbing headaches, tinnitus aurium, blurring of vision, and exertional dyspnea of seven months' duration. The diagnosis of arterial (essential) hypertension was made. (Systolic pressure was reported as 250; diastolic not given.) Bilateral thoraco-lumbar sympathectomy was performed in two stages. The procedure was complicated by a clotted, left hemothorax, requiring pulmonary decortication and evacuation of the clot. The subsequent course was uneventful and a marked hypotensive response followed. She remained asymptomatic until onset of pregnancy in January 1955, when she came under the care of one of the authors (C.M.K.).

Present Pregnancy: The patient had no complaints other than nausea and vomiting in the first trimester and

slight fatigability toward the latter months of the pregnancy. There was a weight range of 135 lbs. prior to pregnancy to 154 lbs. at the time of delivery. The blood pressure varied between 110/60 to 120/70. No cardiac enlargement and no cardiac murmurs.

Laboratory examinations during pregnancy: Rh positive; STS negative; hematocrit 36; blood sugar, urea nitrogen and cholesterol normal, and repeated urinalyses were negative. The electrocardiogram was within normal limits.

Labor Record: Patient was admitted to the Doctors Hospital on October 17, 1955, in labor at term. Her blood pressure on admission was 122/70 and remained static throughout labor. Urine examination was negative. The first stage of labor lasted 18 hours and 50 minutes; second stage, 23 minutes; third stage, 5 minutes; total labor, 19 hours 23 minutes.

First stage analgesia was accomplished by the use of demerol (100 mgs.) and scopolamine (0.4 mg.). For delivery patient received nitrous oxide and oxygen anesthesia. A right medio-lateral episiotomy and low forceps were performed, delivery a normal male infant, weighing 6 lbs. 6½ ounces. Blood loss was 150 cc. (estimated). There was no variation in blood pressure during or immediately after delivery (120/70).

Post-partum course was not remarkable. Blood pressure remained between 110/65 and 120/70. Patient was discharged on October 22, 1955 (5th post-partum day).

Follow-up Examination: She was seen on December 2, 1955. Blood pressure (sitting) was 112/84; (recumbent) 120/82. Eye grounds were normal. Examination of the heart revealed normal sounds. Urinalysis was negative; blood chemistry (including sugar, urea nitrogen, cholesterol) was normal; hematocrit, leukocytes and differential were within normal limits; electrocardiogram and basal metabolic rate were also normal.

COMMENT

Eventually so-called essential hypertension will lead to heart and/or arterial disease. There is no gainsaying that diet (mainly weight-reduction), rest, psychotherapy and drugs should be given a fair trial before considering operation for hypertension. The necessity of frequently repeated blood pressure determinations and the

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constant watchful administration of drugs tend to make the patient more introspective and blood pressure conscious. Surgery then offers hope to this group that fails to respond to the simpler measures of a medical regimen. Despite careful medical management, pregnancy in the hypertensive is hazardous. Litzenberg⁶ said that 30 per cent of hypertensive (essential) pregnant women develop pre-eclampsia; that in this group life expectancy is shortened by pregnancy, and that the infant mortality is high, if eye grounds and congestive failure indicate vascular damage in the mother. Forty to fifty per cent of pregnant women with hypertensive heart disease will develop complications during pregnancy.

Dieckmann⁴ states that Smithwick and the late Peet and their respective co-workers have performed special sympathectomy operations for the relief of hypertensive disease in 42 patients, who subsequently became pregnant. There were 49 pregnancies with 39 live babies, a loss of 20 per cent. In general, the patient who has vascular disease of sufficient severity, warranting some type of sympathectomy, should not undergo pregnancy. Termination of pregnancy should not be instituted before the 32nd week, or later if possible, and only if there is a sudden increase in albuminuria in the 24-hour specimen to 3 grams or more, or an increase of 30 mm. Hg or more in the systolic or 15 mm. Hg or more in the diastolic blood pressure, or where retinal pathology, or oliguria, or hematuria warrants terminations of the pregnancy.

SUMMARY

The case of a 23 year old, white, primigravida is presented. The patient (an identical twin) was a known hypertensive at age 17 with a systolic B.P. of 250 mm. Hg, throbbing headaches, tinnitus, blurring of vision and shortness of breath on exertion.

Bilateral thoraco-lumbar sympathectomy was performed in 1949 following which the patient developed a marked hypotensive response. The

patient has been asymptomatic from a cardiovascular standpoint since and she developed no untoward signs or symptoms during pregnancy and obstetrical delivery at age 23, six years after the Smithwick operation.

CONCLUSIONS

Pregnancy and normal full-term delivery are compatible with a Smithwick operation in selected cases, where a good hypotensive effect follows such surgery.

A great responsibility rests upon the physician in his decision as to the course of treatment of his young female hypertensive patients, who look forward to marriage and a family.

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METASTATIC NEUROCYTOMA OF THE LIVER

Report of a case in a 16 month-old child

HENRY W. SCHEYE, M.D.*

In children after the neo-natal period, malignancy is exceeded only by accidents as the cause of death. The two kidney tumors, Wilms' tumor and neuroblastoma, are high in frequency and usually diagnosed only after reaching either great size or having metastasized to other parts of the body. Both Wilms' tumor and neuroblastoma, at first, are symptomless. Their greatest frequency is at the age of 1-3 years, when children are most difficult to examine and are normally more or less "pot-bellied." The mother is unlikely to be of help, since she seldom notices even extraordinarily enlarged abdominal masses, despite the advantage she has in the intimate handling of her child. Needless to say, examination at this particular age is extremely difficult, and even with a thorough physical examination the diagnosis may be missed easily. Such is the case to be presented at this time.

CASE REPORT

Present Illness: This 16½ months old white male infant was admitted to Doctors Hospital on January 2, 1955, for diagnosis and possible treatment. The child was brought to the office several days prior to admission by the parents who stated that the child, who had not been seen by any doctor for several months, had been apparently very well, had eaten well, gained weight, played normally and had normal eliminations. However, the

mother had noticed an enlargement of the right side of the abdomen for about a month or two, but had not paid too much attention to it, since the child had felt so well.

Past History: The child was born on the 26th of August, 1953, after an uneventful pregnancy and a perfectly normal delivery. He had developed normally and was given his regular routine immunizations between the age of 3 and 6 months. He had taken the usual increase of nourishment and had gained weight properly. At the time of an examination, when about 6 months of age, a growth was noticed on the scalp and the child was referred to a dermatologist, who in turn referred the child to a plastic surgeon. The small scalp tumor was removed on May 7th at Johns Hopkins Hospital. It was totally excised and a portion of the wound was closed, but a small skin graft was inserted in the center. Complete healing took place. The pathological report stated: "linear nevus, but not a true nevus, but a localized area of hyperkeratosis and acanthosis of the type known to dermatologists as linear nevus. Another, perhaps better name, would be keratosis juvenilis." It was completely benign and was completely excised. Following this incident, the child had no more illness, treatment or hospitalization.

Family History: His family history is somewhat interesting, as his maternal grandfather died less than a year ago with a carcinoma of the pancreas, with metastasis to the liver.

Physical Examination: The physical examination revealed a well developed 16½ month old child in no distress. The skin was somewhat pale. Eyes, ear, nose and throat showed no pathology. There was no enlargement of lymph glands. The lungs expanded freely and were clear to percussion and auscultation. The heart seemed to be normal in size and the sounds were normal. The

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abdomen was considerably enlarged, particularly the right side. This enlargement extended from the diaphragm to the upper border of the pelvis and reached to the midline. Superficial vessels were dilated. Palpation revealed that the liver was considerably enlarged. Its edge felt smooth and was palpable just above the pelvic border, ending at the midline. Blood pressure was 100/60. Neurological examination was entirely negative.

Laboratory Examinations: Laboratory examination: hemoglobin 10 grams—70%; red blood cells 3,580,000; leukocytes 12,260; polymorphonuclear 70 per cent; lymphocytes 29 per cent (one band); urea nitrogen 16 milligrams per cent; blood sugar 71 milligrams per cent. Total proteins 3.8 (normal 6–8 grams); serum albumin, 2–3 (normal value is 4.5 to 5.5). The direct Van den Bergh test was 0.16.

X-Ray Examination: Plain film of the abdomen showed a marked ptosis of the right kidney. There was no evidence of radiable calculi. There was an obliteration of the shadow of the psoas muscle on the right side, which obscured the liver shadow. This was reported as probably being due to a tumor in the abdomen, most likely a Wilms' tumor.

Intra-venous Pyelogram: The right kidney was poorly visualized and no diagnosis could be made from that examination.

Surgical Pathology: It was decided, following pediatric and surgical consultation, to do an exploratory laparotomy. At operation the liver was found to be enlarged extremely. It was cystic, showing several large nodules at its base, while the anterior surface and edges were perfectly smooth. A biopsy was taken and the entire abdomen explored; however, there was no evidence of further pathology. The adrenal areas were investigated. There was no evidence of a tumor, as determined by palpation. Microscopic examination of the biopsy material revealed a number of small areas in which a neoplastic growth had infiltrated. This neoplasm was characterized by the presence of a rosette formation and also column cells which resembled the glomerular layers of the adrenals. The rosettes were composed of dense dark elliptical nuclei set in an eosinophilic stroma. There was also a glimpse of an inflammatory change as well as presence of fibroplasia. The final diagnosis made by the pathologist was neurocytoma, adrenal in origin (or neuroblastoma).

Post-Operative Course and Medical Therapy: Following exploratory laparotomy, the child recovered slowly. Various specialists were consulted and it was the general opinion that TEPA or tri-ethelain phosphormide should be tried. It is thought to be beneficial in neuroblastoma, Hodgkin's disease, etc. The preparation was obtained with the assistance of the Lederle Laboratories. The substance, which is suspended in olive oil, was given

intra-muscularly. The average dose is 1.2 to 2.0 milligrams per kilogram in 4 to 6 divided doses over a period of 2 weeks, as suggested by Farber.

The child was discharged from the hospital January 15, 1955. He was seen at home at various intervals; the treatment being continued with TEPA. The results were very poor. He became more anemic and was unable to retain food. Death followed several weeks after discharge from the hospital. An autopsy was not obtained.

DISCUSSION

The case of a 16½ month old infant is described with the final diagnosis of a metastatic neurocytoma in the liver—a tumor which is sarcomatous in appearance, and very malignant.

The origin of neuroblastoma is well known to be the sympathetic nervous system, either in the adrenal medulla or in similar tissue adjacent to the adrenal, or elsewhere in the body. It is known to arise in ganglions such as the celiac plexus, the organs of Zuckerkandl, cervical ganglions and ganglions in various retroperitoneal and retropleural locations, from where extension proceeds along nerve roots to the extra-dural space surrounding the spinal cord. This makes it more understandable that the original tumor, which had caused the metastasis in the liver, was not found at that time. Despite the malignancy of neuroblastomas or neurocytomas or any related tumor of that kind, an early diagnosis is almost impossible. Some cures have followed simple surgical removal of the tumors themselves. Other cures have occurred even with incomplete removal of the tumor, because of spontaneous maturation of the tumor from a malignant neuroblastoma to a benign ganglion neuroma. Few of those tumors are radio-sensitive. Newer drugs, such as tri-ethelain phosphormide, have been found to be beneficial in similar cases. However, in this case tri-ethelain phosphormide proved ineffectual.

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This concludes the Doctors Hospital Issue of the MARYLAND STATE MEDICAL JOURNAL

Report

COMMITTEE FOR THE STUDY OF PELVIC CANCER*

BEVERLEY C. COMPTON, M.D.

Secretary

The Committee for the Study of Pelvic Cancer meets monthly for the discussion of selected cases. All physicians are invited to attend these meetings.

Case 1. A forty-two year old colored female, married, gravida 0. In March 1954, the patient had a right salpingo-oophorectomy and supravaginal hysterectomy. No bleeding following this surgery until November or December 1955, when she noted occasional slight vaginal spotting with one episode of fairly heavy bleeding in December. She went to doctor A's office but as he was away at the time, she was seen by an assistant. A pelvic examination was made. The patient was assured that there was no bleeding at the time and that the examination appeared to be negative. She continued to have very occasional spotting. She consulted doctor A a few times during the next few months regarding digestive complaints. She says that she reported the occasional spotting—was not examined but advised to return if the bleeding recurred. In early June she reported almost continuous bleeding. The patient consulted doctor A and was referred to the hospital where she was seen about June 15th.

Diagnosis: Carcinoma, cervical stump, international classification, stage II, late.

Treatment: Radium and deep x-ray therapy.

Chairman: Does anyone have any further information concerning this case?

Guest physician: Yes, this is my case. This patient was first seen by me in 1953 . . . In March of 1954, she had a supravaginal hysterectomy and a bilateral salpingo-oophorectomy. Your record shows only a right salpingo-oophorectomy. I think this should be corrected. It was a bilateral salpingo-oophorectomy. The operation was difficult and because of operative difficulties, the cervix was not removed. In May of 1955, she came in complaining of hot flushes and was given 20,000 units of estrogen. I was away later that year and the patient was seen in December by the man who was taking over my practice for that time. Evidently he felt that if there had been any bleeding,

it was not much. There was no bleeding at the time of the examination and the cervix looked benign. In April 1956, the patient came to me complaining of digestive symptoms which I thought were probably due to adhesions from her previous operation. In early May she was in the office again and reported symptoms improved. She was seen again in late May complaining of severe hot flushes and was given 20,000 units of estrogen. During these visits she made no complaint of any vaginal bleeding. When she was seen in early June, she complained of continuous bleeding. She was examined but the visible portion of the cervix was not thought to be the source of the bleeding. I made arrangements at this time for her to be seen at the hospital clinic.

Chairman: You say you did not consider the cervix the source of bleeding? The patient had only a cervical stump, did she not?

Guest physician: Yes, but from the part of the cervix which I could visualize, I could not see the source of the bleeding.

Committee member: When the patient was first seen in December of 1955, with a history of slight bleeding, was a biopsy or smear taken?

Guest physician: No. As you know, I did not see this patient at that time. The doctor who did examine the patient felt that the examination was negative and as there was no bleeding at the time, he advised the patient to come back if the bleeding recurred. Nothing further was done at that time.

I thought you would comment on the use of estrogens.

Chairman: If the patient had had a uterus, it might have been a reasonable assumption that the bleeding was caused by the use of estrogens. But this bleeding could not have been coming from the uterus because the uterus had been removed.

What is the feeling about this case? The patient had slight bleeding in December 1955—consulted a physician—was examined and the examination considered negative. She had no bleeding from December to June—at least if she had bleeding it was not reported to her physician. She was a stage II carcinoma of the cervix when seen in the clinic in mid-June.

* Sponsored by the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society.

Committee member: Any bleeding from the cervical stump should be regarded seriously. I think the patient should have had either a biopsy or at least a smear when she was first seen in December. Without much doubt she would have come to treatment earlier if this had been done. The chance of curing a stage I is about twice that of curing a stage II.

Visiting surgeon: In general, how do you feel about doing a biopsy on any cervix that is left in at the time of a hysterectomy?

Chairman: As you know, our policy is to do a pre-operative cervical biopsy on any patient who is to have a hysterectomy, and to have the report of this biopsy before surgery is undertaken. I think it is a good policy. How do some of the rest of you feel?

Committee member: I do not do it if there has been no intermenstrual bleeding.

Committee member: We do not do a routine biopsy. We do a routine Papanicolaou smear and wait for the result.

Committee member: I do a Papanicolaou smear but do not always wait for the result. Sometimes you can't wait that long.

Guest physician: In the counties we do not have the facilities for these pathological examinations. I feel that something must be done about it and that is one of the reasons I am here today.

Chairman: You are quite right and I am very glad to be able to report that something is being done about it. The great delay in receiving reports on Papanicolaou smears has been a great problem to everyone. There simply have not been enough trained cytologists to handle the situation. We are getting a very excellent man who will be in charge of the laboratory and train cytologists. It will take time but we feel that we are on our way to having an adequate service. Of course, as you know, you can send biopsies to a number of pathologists or to the University Hospital or to Hopkins Hospital, and the reports will be sent to you. There is a charge for this except for indigent patients.

Committee member: The ideal treatment would be to have all patients in the age group above thirty-five have a Papanicolaou smear once a year.

Chairman: Yes, ideal—and when the cytologists are available. We are working on it. The American Cancer Society is putting up the money.

Case 2. A colored patient, aged 49, married, gravida 2. The patient gives a history of intermittent pain in the um-

bilical region for a period of three to four years, progressively worse. Menses said to be regular and normal to October 1955. No periods October through January 1956. Beginning in February, bleeding about every two weeks and occasional post-coital spotting. The patient consulted doctor A in March. Pelvic examination was not made. She was treated with douches and various medications. She was told in May that she had a tumor which was causing the irregular bleeding. Patient continued under the care of doctor A until September. At this time she consulted a second physician. Pelvic examination was not made but the patient was immediately referred to the hospital.

Diagnosis: Carcinoma, cervix, international classification, stage I.

Treatment: Radium and deep x-ray therapy.

Chairman: Is there anyone who would care to comment on this case?

Committee member: It is fortunate that this carcinoma was not too far advanced when we saw the patient in the clinic. It was confined to the cervix. The uterus was enlarged and myoma present.

Visiting physician: How do you feel about the use of radium with a large myoma?

Committee member: In this instance the fibroid was up out of the pelvis and the treatment could be more or less routine. In fact, we have seen a good many of these cases where a large fibroid was present and have not altered our treatment. The patients have done very well.

Chairman: Some of the men who like to operate on stage I's, will always do it in the presence of a myoma. I personally do not feel that this is sufficient indication for surgery rather than radiation.

If we do not have any further information on this case, it would appear that there was definite delay on the part of the first physician. The patient was seen over some period of time with the complaint of irregular bleeding and a pelvic examination was not made. Although a fibroid tumor was present, the irregular bleeding should have been investigated. The complaint of post-coital bleeding is particularly important. In the review of cases, it is remarkable how many times this is the first symptom.

Case 3. A white patient, aged 30, married, gravida 4 0 1 4. February 1956, patient first noted post-coital bleeding and intermenstrual spotting. About two months later she became pregnant—L.M.P. April 30, 1956. She says that she continued to have some slight intermittent bleeding. She made her first visit to the pre-natal clinic on September 15th, 1956. No history of irregular bleeding is noted on the record. Pelvic examination made and cervix described as "eroded." Patient

was followed in this clinic with visits about once a month. Clinic history notes "no specific complaints." The patient says she continued to have occasional vaginal bleeding and pinkish discharge. The patient was admitted to the hospital on January 21st, 1957. On January 23rd, labor was terminated by Caesarian section because of failure of the cervix to dilate. (Frozen section biopsy on the 22nd had "disclosed failure to show malignant cells.") Pathological report from the permanent sections showed "squamous cell carcinoma, cervix." The patient was referred to a second hospital for treatment and admitted to the hospital in mid-February.

Diagnosis: Squamous cell carcinoma, cervix, international classification, stage II.

Treatment: Radium and deep x-ray therapy.

Chairman: Does anyone care to comment on this case?

Guest obstetrician: This patient was followed in one of our pre-natal clinics. The pre-natal record is obviously inadequate. The patient says that she had post-coital bleeding and intermenstrual bleeding for two months previous to pregnancy and irregular bleeding during pregnancy. There is no note of this on the clinic history so it appears to be a failure to get an adequate history. At the time of her first visit to the clinic in September she was examined by a competent obstetrician and the cervix described as showing an erosion. This apparently was thought to be a typical erosion and nothing more.

Obviously this lesion might have been picked up by some type of screening test. We have considered doing cervical smears on all patients at the time of the first pre-natal visit, but we would be flooded with class three and class four reports because of changes due to pregnancy. One or two carcinomas might be picked up. Considering we have between thirty-five and forty thousand cases a year it would be a tremendous load for the cytology labs.

Chairman: My first comment on this case would be the use of the word "eroded" as applied to the cervix. I feel this is a term which is used very loosely. I believe the dictionary meaning of the word, as applied to land, means the loss of top soil. I think that real erosion of the cervix should mean the same thing—that is, loss of tissue. In the case under discussion, probably something other than this was described as an erosion.

Committee member: I agree that it is a term that should be more carefully used.

Committee member: I am entirely clear as to why the frozen section biopsy was done in this case.

Guest obstetrician: It is my understanding that the patient was having some bleeding and also that the cervix did not dilate. Because of the bleeding they were suspicious of the possibility of malignancy and they did not want the patient to deliver from below if a malignancy was present. The frozen section was considered negative. The Caesarian was done because of the failure of the cervix to dilate. I believe the Caesarian was done the day following the frozen section.

Chairman: The permanent sections from the same biopsy showed the carcinoma?

Guest obstetrician: That is my understanding.

Chairman: That brings up the question of the use of frozen sections to exclude malignancy. How do some of you feel about this?

Committee member: We do not like them but Mayo's, for instance, would not agree with this.

(There was discussion of the value of frozen sections. It was emphasized that careful technique could greatly increase the value of the sections, but there is great difficulty in getting a technician "disciplined into it.")

Chairman: How should we classify this case?

Committee member: There was certainly patient delay in not giving an adequate history.

Chairman: Yes, and physician delay because an adequate history was not obtained. Also, I can not help but think that the "erosion" described on the cervix was a lesion which should have been biopsied.

Case 4. A fifty-three year old white patient, married, gravida 7. Menopause in 1944. August 1956, slight vaginal bleeding for three days, followed by pinkish vaginal discharge. Consulted doctor A shortly after the onset of symptoms. A pelvic examination was made—patient treated with douches and vaginal medication. The patient says she remained under the care of doctor A and consulted him at intervals of two to three weeks. During September and October she had further intermittent bleeding and increased discharge. In mid-October she was referred to the hospital and admitted.

Diagnosis: Adenocarcinoma, fundus, grade III, with metastasis to the vagina.

Treatment: Radium, intracavitary and vaginal. Deep x-ray therapy.

Chairman: Does anyone wish to say anything concerning this case? Was surgery considered for this patient?

Committee member: We have had difficulty in getting this patient to keep her appointments. She did

not finish her x-ray, and is now delinquent in her appointment to the clinic. The plan is to send her into the hospital for re-evaluation as to surgery. The question is whether or not the vagina is the only metastasis.

Chairman: Doctor A was unable to be here today but he has sent a letter which gives the following information:

"This patient was seen on two occasions in 1954, with pains of the lower quadrant without bleeding. This was considered as an inflammation and treated as such. In August of 1956, she came in because of pains in her lower abdomen and bleeding from the vagina. Pelvic examination revealed foamy discharge but no bleeding. Cervix and uterus were considered normal. The discharge was caused by trichomonads. This was treated and she seemingly improved. In mid-October, the patient was seen again complaining of pelvic pain and discharge from the vagina. Pelvic examination revealed a hard mass in the right side of her vagina with a clear cervix and slightly lumpy feeling adnexa. At this time she was referred to the hospital for further study."

The question seems to be whether or not the doctor was justified in considering the slight bleeding as due to trichomonads. The patient was having no bleeding when she was first seen, although she gave a history of slight bleeding for two days previously.

Visiting surgeon: What do you think of Papanicolaou smear as a screening policy?

Chairman: I think it is excellent. In this particular case I think a smear could have been negative.

Committee member: This physician did make a pelvic examination which appeared to be negative except for vaginitis. I think there was some justification for his belief that the slight bleeding previously was due to vaginitis. From the doctor's letter it is not clear how often he saw the patient in the two months' interim before she was referred to the hospital. The patient says she was seen at intervals of two to three weeks.

Chairman: How do you think this case should be classified?

Committee member: We have had this question before. It seems to be the function of the Committee to determine delay without assigning responsibility. Though there was some justification in assuming that this patient's slight bleeding was due to a vaginitis, the diagnosis later proved to be adenocarcinoma of the fundus.

STATISTICS

Cases to March 1, 1957..... 1417

Classification:

Patient delay.....	590
Physician delay.....	114
Physician and patient delay.....	87
Institutional delay.....	34
Institution and patient delay.....	31
Institution and physician delay.....	5
Institution, physician and patient delay.....	2
Inadequate or improper treatment.....	18
Delay due to laboratory error.....	4
No delay.....	481
Asymptomatic detected cases.....	38
Unclassified to date.....	13

Component Medical Societies



ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.
Journal Representative

The Memorial Hospital, or its predecessors, was the first Hospital to serve the public in Allegany County; now located on Memorial Avenue, Cumberland, Md.

In 1888, a group of Cumberland women established an Old Folk's Home, one of whom was the wife of a physician, Dr. M. A. R. F. Carr. This Home had its beginning at 64 Bedford Street, the former home of a physician.

By an Act of the General Assembly of Maryland, Cumberland became a town on the 20th of January, 1787. Thus, one hundred and one years had elapsed since the town of Cumberland was established, until it had an Institution to care for the aged and infirm. Cumberland had become a railroad town and the many railroad accidents necessitated an Institution for the care of these workers. Up to this time, all injured workmen were treated in the basement of the Queen City Hotel, owned by the Baltimore and Ohio Railroad and were attended by the Company physicians.

In 1889, the Institution was renamed and called the Western Maryland Home and for the first time,



MEMORIAL HOSPITAL, CUMBERLAND, MD.

civilians were treated as Institutional patients. A few years later, the Home and Infirmary was vacated and a new Home was established at Ellen Streets. From this time on, patients began to come in from nearby towns in West Virginia and Pennsylvania, as well as Maryland.

By 1892, four years later, the Hospital activities had outgrown the building facilities and a new building was erected on Baltimore Avenue, by private subscription from the citizens of Cumberland and on November 21, 1892, the Western Maryland Hospital was opened for the admission of patients. The dedication speech was given by Dr. Charles H. Ohr. Dr. J. Marshall Price, of Frostburg, served on the Board of Directors for many years.

On May 30, 1928, the cornerstone of the new Memorial Hospital was laid in Cumberland. Already it was enacted by the General Assembly of Maryland, that the Home and Infirmary of Western Maryland and the City of Cumberland and its Board of Directors be and they are hereby authorized and empowered to sell all its property and assets and convert the same into cash or other securities and to give a sign and transfer of said cash or other securities, to the Board of Governors of the Memorial Hospital, of Cumberland, for its corporate purposes and or to grant and convey all of its said property and assets to said Board of Governors of Memorial Hospital, of Cumberland, for the corporate purposes and be it further enacted that the said Board of the Home and Infirmary of Western Maryland, in the City of Cumberland, after it has given transfer or granted all of its property and assets to the said Board of Governors of the Memorial Hospital, of Cumberland; as authorized in the preceding section shall be and stand dissolved and abolished.

Thus, the Western Maryland Home and Infirmary was in existence from 1889 to 1929, a period of forty years.

On July 23, Memorial Hospital of the City of Cumberland, being the successor of the Western Maryland Home and Infirmary, has now existed from 1929, for a period of twenty-eight years. It is now sixty-eight years old and has a total bed capacity of 254, with a daily census of 208.1; whereas in its first year, it had a total bed capacity of twenty.

Its present Medical Staff consists of twenty-seven physicians on the Active Staff, eight Associate Medical Staff and ten physicians serving on the Courtesy Staff.

Every field of medicine and surgery is covered in its entirety, except brain surgery.

The Allegany Hospital, called Sacred Heart Hospital, of Cumberland, Md. since 1952, is located on Decatur Street. The idea of establishing this Hospital, was born in the mind of the late Dr. Edwin B. Claybrook, one of the pioneer surgeons. Dr. Claybrook was better known for his interest in orthopedic surgery. He was the Chief Surgeon for the Western Maryland and Baltimore and Ohio Railroads for many years and to accommodate the employees (injured) he saw the need for more hospital beds in Cumberland and Allegany County.

The Hospital was incorporated in March, 1905. The original structure was the residence of General Charles Mynn Thruston. The first Board of Directors was composed of citizens and physicians. Those physicians on the Board of Directors were: Dr. Charles H. Brace, Dr. E. B. Claybrook, Dr. Arthur H. Hawkins, Dr. Clinton Brokemarkle and Dr. Charles H. Ohr.

On December 10, 1905, the Hospital was opened for patients. Dr. Claybrook was the second President of the Board of Directors. Six years later, it passed into the hands of the Sisters of Charity (June, 1911). There were twenty-one beds in the original Hospital.

The Medical Staff of the Hospital consisted of the following; Surgeons: Dr. George L. Carder,

Edwin B. Claybrook, Arthur H. Hawkins and Dr. H. S. Wails; General Medicine: Dr. George S. Broadrup, W. R. Hodges, Sr., Edward L. Harris, Charles L. Owens, Edward H. White; Specialists-Eye, Ear, Nose and Throat: Dr. Robert Y. Fectig and Emmett L. Jones, Sr. and Dr. W. R. Foard, Pathologist.

The original name of the Hospital, was the Allegany Hospital of Allegany County, Maryland. In 1911, when the Sisters of Charity became the owner, a new charter was granted the price paid was \$25,150.00. The name was then changed to the Allegany Hospital of the Sisters of Charity, Inc. The real owners of the Hospital being the Sisters of Charity of St. Joseph. On March 7, 1952, the Hospital was renamed Sacred Heart and at this date, the Hospital remains under that name.

The opening year, 1905, two hundred and forty-three patients were treated. In 1917, twelve hundred patients were treated. In 1956, the number of patients treated were 4,801.

The present Staff consists of: Active Staff, 26, Associate and Consulting Staff, 19 and 19 physicians serving on the Courtesy Staff.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Correspondent

At the meeting of the Executive Board on 19 February 1957, Mr. Anderson, our legal advisor, advanced his opinion that the malpractice insurance policy proffered by Lloyd's was advantageous. He quoted the master policy as covering completely the A.M.A. breakdown of the factors tending to favor malpractice suits and giving this area a broader definition than most such policies. It covers assault, slander, libel, and undue familiarity—charges not usually included in malpractice policies. Mr. Anderson felt that Maryland had a favorable situation in the premium gradient among the states and that this was due in large part to the fact that Maryland physicians do cooperate at the cases that come to trial by steadfast attendance. The Board voted to offer the policy to the membership as a measure against the rising tide of costs in malpractice insurance.

Dr. Anthony Perlman spoke before the Board in behalf of the prophylaxis program of the Heart Association of Maryland. The Board questioned



SACRED HEART HOSPITAL, CUMBERLAND, MD.

the proposed distribution of the prophylactic penicillin preparation via pharmacies. It is proposed to provide the specified prophylactic penicillin tablet costing twenty-two cents for dispensing at five cents on prescription having a physician's certification of medical indigence. Approval was voted, but several members thought that direct provision of the tablets via the physician would effect a saving.

The poliomyelitis vaccination program presented by Dr. Huntington Williams, Health Commissioner of Baltimore City, was approved and the Medical Education Committee was designed for liaison with the central coordinating committee.

Thoughtful consideration was given to the voting on the amendment for proposed change in the selection of the officers of the Society. Dr. Moses Paulson, chairman of the Constitution and By-Laws Committee, thought that the voting showed a sentiment in the Society for a change in the selection of the Nominating Committee. His Committee set a meeting for 27 February with the proponents of the defeated amendment and the Executive Board. It was considered that the Nominating Committee might consist of the three most recent past presidents and two or three elected from the floor. A suggestion attributed to Dr. Wetherbee Fort was that the selection of the second vice president might be widened and combined with the challenge and obligation of four years of service and thereby learning the many phases of the president's duties to the Society and the community. Dr. Amos Koontz suggested that the amendment provide for posting of any proposed slates of officers at least six weeks in advance of the meeting at which election is to take place.

The question was raised as to whether officers in the Sections, as well as those of the Society, must be active members, or could they be associate members. It was agreed that officers of the Sections must be active members, not merely associate.

A letter was read from Dr. Herman K. Goldberg. He stated that at a recent meeting of the Baltimore City Society Eye Section, a resolution was passed by a vote of 17 to 2 that the ophthalmologists be given the privilege of having in the telephone book, under a regular physicians and surgeons listing, a line which states "practice limited to ophthalmology." There was the usual discussion, ending with the usual dead end: Who is to say who is qual-

ified? The Executive Board?, The Sections?, The Telephone Company? Any method has disadvantages. It was again the unanimous opinion of the Board that this should be disapproved. Some of the bad practices this had led to in other cities were emphasized. The secretary, Dr. Classen was directed to notify the Telephone Company that such listing was against the policy of the Baltimore City Medical Society.

A letter from the Mayor regarding medical liaison with his newly appointed Re-Zoning Committee was read and transmitted to Dr. Wetherbee Fort, chairman of our Re-Zoning Committee.

A letter was read from a member claiming that seventy-five per cent of the membership were 'disfranchised' by the small size of Osler Hall.

Another letter expressed appreciation and thanks for the distribution of the President's Report for 1956 to the membership at large. Even though he was unable to attend the meetings, this writer was interested in the Society. The distribution of this Report made him feel more in touch with the Society and more fully a member.

* * *

The regular meeting of the City Medical Society was held Friday, 8 March 1957. The President, Dr. Francis J. Geraghty introduced Dr. Hans Wodak, President; and Dr. William B. Hagan, Delegate, of the Prince George's County Medical Society and Dr. Walter H. Shealy, President; Dr. J. Walter Layman, Vice-President; and Dr. Ernest F. Poole, Secretary, Treasurer, of Washington County Medical Society who were guests of the Baltimore City Medical Society for the Meeting.

Although the weather and 'disfranchisement' reduced the audience to a handful, it proceeded to elect new members, endorse the Baltimore City Health Department's Resolution on Poliomyelitis Vaccine Program, and get on with the Scientific Session with celerity.

Dr. Walter E. Bauer, Chief of Medicine, Massachusetts General Hospital, Boston, spoke on "Gout—A Forgotten Disease" with great lucidity and fine pictures. The audience was enthusiastic and asked discriminating questions at some length.

After the meeting the Woman's Auxiliary had no coffee or doughnuts. They instead had a "Cruise

Ball" at the Emerson Hotel and, with our enthusiastic cooperation, cleared more than a thousand dollars for their charitable enterprises. "Glad to have been aboard" and a "Well done!" to their president, Mrs. Ellsworth Cook, Mrs. Raymond Rangle, chairman, and her hardworking committees.



BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

The February meeting of the Baltimore County Medical Association was held on February 20, 1957 at the Stafford Hotel in downtown Baltimore. This luncheon meeting was held with the Ladies Auxiliary. Mrs. Homer Todd, State President of the Ladies Auxiliary was present.

A great deal of time was devoted to a discussion of the Polio Campaign. Many civic groups and individuals have strongly criticised the Medical Society since its January meeting. At that time, a resolution was passed concerning the availability of the vaccine and a suggested fee. The public apparently feels that since they have been donating to the Polio Foundation for so many years, they are now entitled to vaccination free of charge. Dr. Louis Dalmau discussed the plans of the National Foundation for Infantile Paralysis in regard to free and at-cost clinics. It was resolved by the County Medical Society that no state or national emergency exists to justify any free polio clinics with the exception of those that exist for the medically indigent. The Baltimore County Medical Association will adhere to the policies outlined by the American Academy of General Practice that "voluntary and public health agencies would do better to devote their energies and funds toward public education to encourage people to seek immunization at their doctors office or health clinics."

In cooperation with the secondary school health program, forty-nine members of our society have volunteered their services for indigent children and emergencies. This action will be further publicised.

The committee on Hungarian Refugee Physicians recommended that no change be made in the existing law for licensure; this recommendation followed

their investigation of the requirements for medical licensure for physicians trained in foreign countries. These requirements have been explained in a past issue of the Journal of the American Medical Association. The law is good and fair, and such doctors are especially well-treated in Maryland.

Dr. John Hyle of the Hospital Committee gave a detailed report regarding the recent questionnaire sent to the membership. Franklin Square Hospital is considering a move to Baltimore County. The Towson area seems to be the favored location. A General Practice Section will be established on the hospital staff. Real estate, financing and population density are the largest problems to be studied. Other meetings will be held with the hospital board.

The scientific portion of the meeting was devoted to an excellent presentation by Dr. Joseph Workman, Assistant Professor of Medicine at the University of Maryland School of Medicine. Dr. Workman is also Co-director of the Radio-Isotope Laboratory at the University Hospital. His topic was "Modern Diagnosis and Treatment of Thyroid Diseases." He discussed thyroiditis in particular. His talk was most interesting and very well received.

CARROLL COUNTY MEDICAL SOCIETY

JULIUS CHEPKO, M.D.

Journal Representative

The regularly scheduled meeting of the Carroll County Medical Society was held at Hoffman's Inn, Westminster, on March 6, 1957.

It was proposed that county-wide publicity be given to the fact that all individuals between the ages of 3 months and 40 years should avail themselves of the polio vaccine inoculations during the months of March and April. This was done by contracting, via letter, phone and otherwise, all the county newspapers, Service Clubs and Radio Station WTR by the Journal representative. Also, it was decided to adjust the fees to conform to the recommendation of the Medical and Chirurgical Faculty of the State of Maryland.

Lt. Colonel Colin Francis Vorder Bruegge, U. S. Army Medical Unit, Fort Dietrick, Maryland, presented a very interesting discourse on Abnormal Hemoglobin, limiting his talk to Sick Cell Disease. Col. Bruegge pointed out that, the individual who

is borderline from the viewpoint of sickling develops a chronology of symptoms in somewhat the following fashion: a healthy appearing male presents himself with painless, spontaneous hematuria, stating that otherwise he feels fine. Upon laboratory and cystoscopic examination, it is found that one ureter only, usually the left ureter, is found to be discharging blood. Occasionally nephrectomy must be done, as a life saving measure. The kidney shows the following changes: dense deposits of hemosiderin in the tubules; capillaries and glomeruli become engorged and occluded with blood cells; finally, the tubules become so occluded that they are obscured. This process progresses until the engorgement is so great that the papillae of the kidney necrose, due to excessive pressure. This type of patient's spleen will swell at high altitudes of flight, often necessitating immediate splenectomy. Aseptic necrosis of joints occurs more often in this type of patient. In the eye the changes are seen in the extreme periphery of the eyegrounds, showing tortuous vessels and lakes of blood, giving way gradually to white patches and finally fibrosis.

The second speaker, Lt. Colonel Edwin Overholt, also from Fort Dietrick, discussed "Round Lesions of the Lung." These are usually found, Col. Overholt stated, on routine examination and present an interesting problem in differential diagnosis. Following are several of the conditions found, as shown by Col. Overholt:

1. Arterio-venous fistula from the heart, which is characterized by an afferent-efferent loop, multiple angiomas on lips and/or face (telangiectasia) and severe epistaxis.
2. Bronchogenic cyst (infected) looks like a lung abscess.
3. Encapsulated Empyema.
4. Bronchogenic Carcinoma—no calcium deposit in the lesion.
5. Granulomata—calcification seen in the entire mass of lesion
 - a. Coccidiomycosis (thin wall when cavities)
 - b. Histioplasmosis
 - c. Tuberculosis

Skin tests are of help at times in the differential diagnosis of granulomata. On the other hand, there are some patients who react to all skin tests; therefore, the search must be directed to other facets.

If the lesion is relatively large, a resection is indicated. If the patient is over 40 years of age, removal is recommended because of the possibility of carcinomatous degeneration.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

The regular February meeting was held at the Francis Scott Key Hotel on the 19th. The speaker was Dr. H. C. Marriott, who gave a "dichotic" talk. The first portion was an informative presentation of the more common pitfalls besetting the "pure" electrocardiographic diagnosis of cardiac pathology. The second was on medical aphorisms, many of which were derived from Osler. It was most delightful.

HOSPITAL NEWS

The surgical staff met on the 11th and discussed the causes of death in the following cases: fracture of femur, fracture of skull, carcinoma of pancreas, gunshot wound of the abdomen, gangrene of the small bowel caused by adhesions and finally a case of calculus in the common bile duct.

The medical staff met on the 22nd and discussed the case of a 4 year old child with meningococcal meningitis who died within 24 hours of hospitalization and the case of a 70 year old colored woman who died from a cerebro-vascular accident.

The case at the February Clinico-Pathologic Conference was that of a intercapillary glomerular sclerosis in a 61 year old diabetic woman who died in uremia. There followed a discussion of various systemic effects of diabetes and the properties and pharmacology of the various types of insulin and the experimental findings in the use of the new oral hypoglycemic sulfonamide compounds.

Necrology*

W. E. Moseley, Jr. M.D.

1882-1956

Dr. W. E. Moseley, Jr., was the son of Dr. W. E. Moseley and Elizabeth B. Moseley, of 614 North Howard Street, Baltimore, Maryland. He was born 8 December 1882. His mother was the daughter of Dr. William Riley (1807-1887) a portrait of whom hangs in the Medical and Chirurgical Faculty Building.

W. E. Moseley, Jr., was educated at the Marston University School on Cathedral Street. Later he attended the Tome School at Port Deposit. In 1906 he was graduated from the old Baltimore Medical College, of which Dr. W. E. Moseley, Sr., was Professor of Gynecology.

After practicing in the middle West and in Toledo, Ohio, for some years he became Medical Examiner for the B. and O. Railroad in West Virginia. Finally he settled in Mt. Savage, Md., about 1946.

On 19 September 1955 he suffered a cerebral accident, from which he never recovered. He died 21 November 1956. He is survived by his widow and a son, W. E. Moseley, III (by a former marriage), and by two grandchildren, Sharon Ann and W. E., IV.

Dr. Moseley did a great deal of obstetrical work and after a delivery would often say, "That child is born with a good normal brain. I hope the parents do something to develop it."

A. S. C.

* Memoir Committee: A. S. Chalfant, M.D., *Chairman*, John F. Hogan, M.D. and Robert H. Riley, M.D.

Anderson J. Fazenbaker, M.D.

1894-1957

Dr. Anderson J. Fazenbaker, born in 1894 in Bloomington, Garrett County, Maryland, son of Dr. Charles J. Fazenbaker, died on February 22, 1957. He had practiced medicine in Westernport for the past thirty-five years.

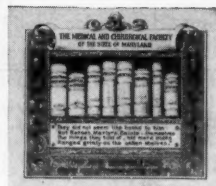
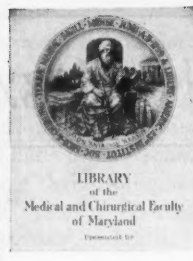
Dr. Fazenbaker graduated from the University of Maryland Medical School in 1918 and served his internship at Mercy Hospital and St. Joseph Hospital, Baltimore, Maryland. From 1919 to 1922, he was Chief Surgeon at Northern Main General Hospital, Eagle Lake, Maine.

Dr. Fazenbaker held membership in the Allegany-Garrett County Medical Society and the American Medical Association. He was a Mason and a member of St. James Episcopal Church. From 1932 to 1934, he was Health Officer of Westernport and he was a member of the Westernport City Council from 1934 to 1938.

He was truly a friend of the unfortunate. Although all but helpless physically for many years, with his devoted wife's help, he carried on an extensive practice.

Arthritis deformities and a slowly weakening heart never erased the smile from his face.

Leslie E. Daugherty, M.D.



Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

LIBRARY CHATTER

LOUISE D. C. KING

Librarian

We, as a nation, are very apt to be disdainful of other cultures than our own and because many of them are primitive and have in our eyes, grotesque features, we discard them as worthless.

Some of the tribes of the Indians of North, Central and South America attained a high degree of culture along many lines of which the visual remains have been preserved for us, but for the most part, we scoff at their medical lore. We read about the medicine-man in his fantastic garb, his grotesque gyrations and his weird incantations, forgetting that diversion and hypnosis are both adjuncts of modern medicine.

Medicine as a science and art, has not grown to its present efficacy from a single source or country but rather is a composite result of all that has been found good throughout the world and down through the ages.

Although the Indian has not perhaps contributed so large a share to our progress as some other races, there are a few drugs which have come down to us and are still in the United States Pharmacopoeia. Among these is *Arbor Vitae* which the Indians soaked in bear fat and used in the treatment of rheumatism. We occasionally use it as a mild counter irritant and during World War II it took the place of unobtainable lavender oil in soft soap liniment. The wild black cherry which we now use as a

flavoring for cough mixtures was for them a food and an astringent. *Cascara Sagrada* is known in all households. We still use *Jimson Weed* which is similar in its action to *Belladonna* and was known to the Indian as a stimulant and narcotic. *Wintergreen* was also their remedy as well as ours for rheumatism. There are many others with which one is familiar although they have been removed from the United States Pharmacopoeia, some quite recently, such as slippery elm, ipecac, sarsaparilla, cinchona and that ubiquitous weed, tobacco.

They had theories and practices which were interesting: dreams for instance, they thought were the wanderings of the soul while the individual slept. They chewed their maize into a pulp because they knew saliva contained medicinal or digestive properties and one method of treatment was to apply live stinging ants to the abdomen of the patient (formic acid?). Far be it from us to recommend the procedure literally, but after eating, the Indian wiped his greasy hands on his hair—result—no baldness. Many tribes constructed sweat houses, where stones were heated, then water poured over them, thus creating a steam bath. The medicine man collected his fee in advance, but failure to cure the patient made it mandatory to return the fee, and should two or three of his patients have the misfortune to die after a prognosis of recovery, the medicine man might be put to death.

There are many fascinating books and articles on the Indian and his medical lore, a few of which we list below. These may be obtained from your own library.

- Clendenning, L. Behind the doctor. 1933, p. 3-36.
- Corlett, W. T. The medicine-man of the American Indian. 1935.
- Mooney, James. The Swimmer manuscript, Cherokee sacred formulas and medicinal prescriptions. 1932.
- Stone, Eric. Medicine among the American Indian. 1932.
- Brooks, H. The medicine-man of the American Indian. Bull. N. Y. Acad. Med. 5: 509-537, 1929.
- Hrdlicka, A. Disease, medicine and surgery among the American aborigines. J.A.M.A. 99: 1661-1666, 1932.
- Jones, H. Practice of medicine among our aborigines. Ann. Med. Hist. 2: 436-439, 1930.
- Major, R. H. Aboriginal American medicine. Ann. Med. Hist. 10: 534-547, 1938.
- Opler, M. E. Some points of comparison. . . Am. J. Psychiat. 92: 1371-1387, 1934.
- Stone, E. Medicine among the Iroquois. Ann. Med. Hist. 6: 529-539, 1934.

ANNUAL OTOLARYNGOLOGY ASSEMBLY

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from September 30 through October 6, 1957. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose and throat.

Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Poliomyelitis Vaccine and Children

"Any Child Not Protected is Neglected."

Huntington Williams, M.D.

Commissioner of Health

STATE DEPARTMENT OF HEALTH

A Program of Heart Disease Control in Montgomery County

A special program, whose purpose is to evaluate the use of the 70 mm photofluorogram as a heart disease case finding device, is currently being conducted by the Montgomery County Health Department under the direction of Dr. William J. Peeples, with the cooperation of the Montgomery County Tuberculosis and Heart Association, the Maryland Heart Association and the Heart Disease Control Program of the Division of Special Health Services of the Public Health Service.

After many months of careful planning, with representatives of the Montgomery County Medical Society, this study was put into operation in October 1956. It utilizes the 70 mm films being taken each month by the Mobile X-Ray unit, under the auspices of the Montgomery County Tuberculosis and Heart Association. A minimum of twenty thousand consecutive films will be read both by a physician trained in tuberculosis detection and by a roentgenologist, looking specifically for cardiomegaly or other cardiovascular abnormalities. The facilities of the Health Department Chest Clinic in Rockville are being utilized to obtain 14 x 17 inch chest films on all patients with suggestive, but not obviously abnormal photofluorograms. The roentgenologist's report of the 14 x 17 film or in the case of obvious defects, the 70 mm film, is sent to the patient's private physician along with a request for the return of specific data from the physician's examination as to the cardiovascular diagnosis, severity, duration since onset, therapy required, if any, and of most

interest, whether or not the diagnosis had been previously made.

The program is especially designed to study those patients under 55 years of age, showing minimal evidence of cardiac disease as it is believed that it will be from this group that the greatest number of previously undetected cases will be found. However, abnormalities at any age are being reported to the patient's physician, as are all incidental or insignificant findings.

The success of this trial program and the value of the information to be gained from it, depends very heavily upon the mutual cooperation of each patient, his own physician and the Health Department. To date, Dr. Peeples reports, the program is running very well and the acceptance by the patients and private physicians of the responsibility for following through with the suggested examinations and returning the requested information forms has been quite satisfactory. Smooth operation of the study, in particular the tactful handling of the increased anxieties aroused in patients by the recalls for large films has been greatly facilitated by the utilization of the Medical Social Consultant of the Health Department's Tuberculosis and Chronic Disease Division. These services have proved to be of great value and records are being kept of each patient or physician contact in an attempt to evaluate the amount of anxiety created and the type of help which produces the most satisfactory Patient-Doctor-Health Department relationship.

At the present rate of about 2500 survey films per month, it is anticipated that the initial screening will be completed during the month of May and that the follow-up reports will be accumulated until mid-summer. At that time analysis of the data compiled will provide valuable information as to the prevalence of heart disease in Montgomery County, and the efficacy of using the Mobile Chest X-Ray Survey as a case finding device for unsuspected heart disease.

Henry H. Nathan

Director

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, March 29-April 25, 1957

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County . . .	71	—	1	—	5	—	63	—	—	—	16	—	—	—	6	1	6	e-1	2
Anne Arundel	6	—	3	—	3	—	8	—	—	—	—	—	—	—	7	1	1	—	2
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	—
Harford	—	—	—	—	—	—	1	—	—	—	4	—	—	—	1	—	—	—	1
Carroll	1	—	—	—	—	—	—	—	—	—	10	—	—	—	—	—	—	—	2
Frederick	12	—	1	1	2	1	22	—	—	—	—	—	—	1	2	—	1	t-1	2
Washington	9	—	1	—	—	—	—	—	—	—	1	—	—	—	5	—	—	—	3
Allegany	7	—	—	2	—	—	3	—	—	—	59	—	—	1	1	—	—	—	2
Garrett	1	—	—	—	—	—	2	—	—	—	—	—	—	—	—	—	2	—	—
Montgomery	44	—	17	—	63	—	99	—	—	—	49	—	—	—	3	—	1	e-1	5
Prince George's	10	—	6	—	4	—	32	—	—	—	8	—	—	—	1	—	—	a-2	—
Calvert	—	—	—	—	1	—	—	—	—	—	2	—	—	—	2	—	—	—	—
Charles	—	—	—	2	1	—	—	—	—	—	1	—	—	—	—	—	—	—	—
Saint Mary's	7	—	7	—	2	—	1	—	—	—	—	—	—	—	—	—	—	—	2
Cecil	—	—	—	6	—	1	1	—	—	—	2	—	—	—	1	1	1	—	3
Kent	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Caroline	7	—	—	—	1	—	2	—	—	—	—	—	—	—	1	—	—	—	1
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
Dorchester	—	—	—	—	1	—	—	—	—	—	5	—	—	—	1	1	—	—	1
Wicomico	20	—	—	3	47	—	3	—	—	—	7	—	—	—	1	—	5	—	1
Worcester	—	—	—	4	9	—	1	—	—	—	—	—	—	—	—	—	1	—	1
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5	—	1	—	—
Total Counties	195	0	36	18	139	2	239	0	0	0	164	0	0	2	40	6*	19	—	31
Baltimore City	178	0	18	3	22	0	109	0	0	0	28	0	0	10	68	10	476	—	24
State																			
March 29-Apr. 25, 1957	373	0	54	21	161	2	348	0	0	0	192	0	0	12	108	16	495	—	55
Same period 1956	409	0	192	10	1402	9	404	0	0	0	103	2	0	13	170	20	489	—	66
5-year median	558	1	106	34	860	4	285	1	—	0	230	1	2	24	184	15	480	—	66
Cumulative totals																			
State																			
Year 1957 to date . . .	1408	1	118	59	363	10	1203	0	0	0	525	1	0	71	567	79	2150	—	271
Same period 1956 . . .	1698	0	450	50	7605	26	1428	1	0	0	446	3	0	64	702	102	2007	—	331
5-year median	2128	5	298	136	4410	23	1040	3	—	0	952	5	5	112	701	75	2168	—	322

a = amoebic dysentery

c = congenital syphilis, under 1 year of age

e = encephalitis, from mumps

t = tetanus

* = total includes 2 cases reported from State Hospitals.



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. GERALD W. LEVAN, *Auxiliary Editor*

SO GLAD YOU'VE JOINED US!!

A most cordial welcome to 54 new members who have recently joined our group. We feel congratulations are in order for the component auxiliaries lucky enough to have these fine women as new members, and we know that both the organizations and the individual members will benefit from the association. An extra pat on the back to Baltimore City which has given us 30 of these new members: Mrs. Michael Abrams; Mrs. Elikee Allinson; Mrs. Daniel Bakal; Mrs. Peter Ball; Mrs. Edward Barczak; Mrs. S. H. Barranco; Mrs. Matthew Debuskey; Mrs. Jerome Gabor; Mrs. Milton Ginsberg; Mrs. C. R. Green, Jr.; Mrs. John L. Graw; Mrs. Martin Helrich; Mrs. E. Douglas Horning; Mrs. Nathan Hyman; Mrs. Harry C. Kaine, Jr.; Mrs. Robert Kimberly; Mrs. John Krejci; Mrs. Benjamin B. Lee; Mrs. J. G. Miller; Mrs. Paul E. Molumphy; Mrs. James S. O'Hare; Mrs. Melvin Polek; Mrs. Samuel Rubin; Mrs. Morris Stenberg; Mrs. John F. Strahan; Mrs. Adam Swiss; Mrs. Umberto Villa-Santa; Mrs. Emerson Walden; Mrs. W. Wallace Walker; Mrs. A. Dougal Young.

From Baltimore County we welcome: Mrs. Frank T. Casick, Jr. and Mrs. George Gilmore.

From Montgomery County: Mrs. Robert Angle; Mrs. Alejandro Castro; Mrs. John R. Conley; Mrs. Donald Q. Ekman; Mrs. Julius Fogel; Mrs. Herbert J. Jacobs; Mrs. Linwood H. Johnson, Jr.; Mrs. Emmett Patrick Madigan; Mrs. James P. McCarrick; Mrs. John H. McLeod; Mrs. Henry W. Stout; Mrs. John B. Tuohy, Jr.; and Mrs. John B. Umhau, Jr.

From Prince George's County: Mrs. Leonard Dietz; Mrs. Harry E. Ferris; Mrs. Arnold A. Lear; Mrs. Louis Mendel; Mrs. Robert Reilly; Mrs. George W. Ware.

From Washington County: Mrs. Richard T. Binford; Mrs. Joseph C. Crisp; Mrs. Paul Harrison.

And from Howard County, we welcome Mrs. Irving J. Taylor as a member-at-large.

A hearty welcome into the Auxiliary family to all new members. We feel sure they will find the affiliation deeply rewarding and know they will contribute much to the Auxiliary.

The Annual Convention of the Woman's Auxiliary will be held in Baltimore, May 1-3, and at this time we are happy in the thoughts of greeting all of our new members and extending to you a cordial hand of fellowship and hearty congratulations. "Getting to know you" will be our dream come true! Then, too, we want you to share in our fun and participate in our Auxiliary achievements.

IF

IF everyone who drives a car could lie a month in bed
With broken bones and stitched-up wounds, or
fractures of the head,
And there endure the agonies that many people do;
They'd never need preach safety any more to me
or you.

IF everyone could stand beside the bed of a close
friend,
And hear the doctor say, "no hope," before that
fatal end,
And see him there unconscious, never knowing what
took place,
The laws and rules of traffic I am sure we'd soon
embrace.

IF everyone could meet the wife and children left
behind,
And step into the darkened home where once the
sunlight shined,
And look upon the vacant chair where Daddy used
to sit,
I'm sure each reckless driver would be forced to
think a bit.

IF everyone would realize pedestrians on the street
Have just as much the right-of-way as those upon
the seat,

And train their eyes for children who run recklessly
at play,

This steady toll of human lives would drop from
day to day.

IF everyone who drives a car would heed the danger
signs

Placed by highway engineers who also marked the
lines

To keep the traffic in the lane and give it proper
space,

The accidents we read about could not have taken
place.

And last—if he who takes the wheel would say a
little prayer,

And keep in mind those in the car dependent on
his care,

And make a vow and pledge himself to never take a
chance,

The great crusade for safety then would suddenly
advance.

—S. Sam Taylor

SCIENTIFIC AND CLINICAL CONFERENCE

American Association of Rehabilitation Therapists
Association for Physical and Mental Rehabilitation
Association of Medical Directors and Coordinators

The convention of the joint organizations above will be held at the Conrad Hilton Hotel
in Chicago on July 7 to 12, 1957.

COMING MEETINGS

Joint Committee on Maternal Morality, City Health Dept. and B.C.M.S.

Thursday, June 27, 1957 4:00 P.M. 1211 Cathedral Street

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Semiannual Meeting Medical and Chirurgical Faculty

Friday, September 20, 1957 Commander Hotel

Ocean City, Maryland

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All meetings are held in the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore, Md., unless otherwise designated.

Television and radio programs presented in conjunction with the Baltimore City Health Department and the Medical and Chirurgical Faculty:

Television Station WMAR-TV

"Your Family Doctor"

Friday 5:15 P.M.

Radio Station WFBR

"Keeping Well"

Monday 10:15 P.M.

- June 3 "The Deadline" (polio vaccine inoculations)
10 "The Death House" (a case of lead poisoning)
17 "Road Hazard" (child safety)
24 "Black Widow" (spider control)

REFRESHER COURSES AT MARYLAND GENERAL HOSPITAL AND HOSPITAL FOR THE WOMEN OF MARYLAND

Refresher courses designed primarily for nurses who have been inactive in hospital nursing and feel a need for current information are available without cost at the Maryland General Hospital and Hospital for the Women of Maryland, Baltimore. Lectures, demonstrations and supervised practice are provided three days per week for a period of six weeks. Classes are enrolled at six week intervals. Nurses who are interested should communicate with the Director of Nurses of the respective hospitals.